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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03334 **CERTIFICATE OF DEATH** 03327

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): SILVER SPRING
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): 8513-CARROLL AVENUE

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: MONTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 20 SILVER SPRING
d. STREET ADDRESS: 8513-CARROLL AVE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First MIRIAM Middle - Last AARONSON

4. DATE OF DEATH: Month MARCH Day 10 Year 1962

5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Aug-11-1921
9. AGE (In years last birthday): 40 yrs. IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): —
10b. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (County & State, or foreign country): BALTO., MD.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: WOLF AARONSON
14. MOTHER'S MAIDEN NAME: SARAH GRUSDA

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes give war or dates of service): -
16. SOCIAL SECURITY NO.: NONE
17. INFORMANT: HENRY AARONSON (BRO). Address 906 NAVAHOE DR. SSPG MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CEREBRAL HEMORRHAGE — INTERVAL BETWEEN ONSET AND DEATH: 36 hrs.
273 X
DUE TO (b) Hypoplastic ANEMIA — over 15 yrs
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) No
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from APRIL 28, 1947 to MARCH 10, 1962 that (I) (we) last saw the deceased alive on MARCH 10, 1962, and that death occured at 10:05 AM, from the causes and on the date stated above.

22a. SIGNATURE: Israel Kessler, M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 3/10/62
22c. PHYSICIAN'S NAME (Type): ISRAEL KESSLER, M.D
22d. ADDRESS: 801-16th St. N.W.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 3/11/62
23c. NAME OF CEMETERY OR CREMATORY: B'NAI ISRAEL CEM
23d. LOCATION (City, town or county) (State): OAK HILL, MD

24. FUNERAL DIRECTOR'S SIGNATURE: Goetting Funeral Home
ADDRESS: 4217-9th Ave
25a. REC'D BY REGISTRAR DATE MAR 12 '62
25b. REGISTRAR'S SIGNATURE: Carlton S. Kruse

VR A15 (4)
15M 7/61

# MARYLAND STATE DEPARTMENT OF HEALTH

**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

03335 **CERTIFICATE OF DEATH** 03328

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**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed in 24 hours after death. Page 4 should be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Montgomery
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Olney
c. LENGTH OF STAY IN 1b: 15 minutes
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Montgomery General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Gaithersburg
d. STREET ADDRESS: Route 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First / Middle / Last: Irving Leo Aleshire

4. DATE OF DEATH: Month: mar. Day: 18 Year: 1962

5. SEX: male
6. COLOR OR RACE: white
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: March 17, 1922
9. AGE (In years last birthday): 40 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Road Department
10b. KIND OF BUSINESS OR INDUSTRY: Truck Driver
11. BIRTHPLACE (County & State, or foreign country): Luray, Va.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John Aleshire
14. MOTHER'S MAIDEN NAME: Hester ~~Maiyck~~ Smith

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): Yes
16. SOCIAL SECURITY NO. (If yes give were or dates of service): WW # 2 578-20-0706
17. INFORMANT: Hospital Records
Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) PULMONARY EDEMA, ACUTE — INTERVAL BETWEEN ONSET AND DEATH: 1 hour
420.1
DUE TO (b) MYOCARDIAL INFARCT, OLD, HEALED — SEVERAL MONTHS
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c) CORONARY ARTERIOSCLEROSIS

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e): DIABETES MELLITUS - (HYPERNEPHROMA L. KIDNEY) INCIDENTAL FINDING
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 3/17 1962 to 3/18 1962, that (I) (we) last saw the deceased alive on 3/18 1962 12:00 A.M., and that death occured at M, from the causes and on the date stated above.

22a. SIGNATURE: G F Meadors M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 3/18/62
22c. PHYSICIAN'S NAME (Type): G.F. MEADORS, MD.
22d. ADDRESS: DAMASCUS, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 3/21/62
23c. NAME OF CEMETERY OR CREMATORY: Montgomery Meth.
23d. LOCATION (City, town or county) (State): Clagettsville, Md.

24 FUNERAL DIRECTOR'S SIGNATURE: Olin L. Mobsworth
ADDRESS: Damascus, Md.
25a. REC'D BY REGISTRAR DATE MAR 22 '62
25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

VR A15 (4)
15M 7/61

(M)

# MARYLAND STATE DEPARTMENT OF HEALTH

**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

03336 **CERTIFICATE OF DEATH** 03329

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**1. PLACE OF DEATH** a. COUNTY: MONTGOMERY MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BETHESDA
c. LENGTH OF STAY IN 1b: 12 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): SUBURBAN

**2. USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
a. STATE: MARYLAND b. COUNTY: MONTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 44 BETHESDA
d. STREET ADDRESS: 5822 LONE OAK DR.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

**3. NAME OF DECEASED** (Type or print): First NELLIE Middle R. Last ALLEN

**4. DATE OF DEATH** Month MARCH Day 10 Year 19 62

**5. SEX** FEMALE **6. COLOR OR RACE** WHITE **7. MARRIED** ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

**8. DATE OF BIRTH** 4/25/81

**9. AGE** (In years last birthday) 80 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): RETIRED
**10b. KIND OF BUSINESS OR INDUSTRY**:
**11. BIRTHPLACE** (County & State, or foreign country): CAMBRIDGE, MARYLAND
**12. CITIZEN OF WHAT COUNTRY?** U.S.A.

**13. FATHER'S NAME** NICHOLS G. HENRY
**14. MOTHER'S MAIDEN NAME** CORNELIA RADCLIFFE

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unkown) NO
(If yes give wars or dates of service):
**16. SOCIAL SECURITY NO.** Yes
**17. INFORMANT** DAUGHTER, MRS. BETTY MOSSBURG Address

**18. CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

MEDICAL CERTIFICATION

PART I. DEATH WAS CAUSED BY: INTERVAL BETWEEN ONSET AND DEATH

IMMEDIATE CAUSE (a) Pulmonary artery thrombosis — Hrs to few days
420.1
DUE TO (b) Myocardial infarct — 12 days
DUE TO (c) Coronary atherosclerosis — years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Diabetes

**19. WAS AUTOPSY PERFORMED?** YES ☒ NO ☐

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**20a. ACCIDENT WAS UNDERLYING** ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)
**20b. DESCRIBE HOW INJURY OCCURED.** (Enter nature of injury in Part I or Part II of item 18.)
**20c. TIME OF INJURY** Hour a.m. p.m. Month, Day, Year 19
**20d. INJURY OCCURRED** While at work ☐ Not While at work ☐
**20e. PLACE OF INJURY** (Home, farm, factory, street, office bldg., etc.)
**20f.** (City or town) (County) (State)

**21. I certify** that (I) (this hospital) attended the deceased from 1957 to March 9, 1962 that (I) (was) last saw the deceased alive on March 9 1962 and that death occured at 6:20 A.M. from the causes and on the date stated above.

**22a. SIGNATURE** Allen J. O'Neill M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
**22b. DATE SIGNED**
**22c. PHYSICIAN'S NAME** (Type) Allen J. O'Neill, MD
**22d. ADDRESS** 8601 Old Georgetown Rd Bethesda Md.

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**23a. BURIAL, CREMATION, REMOVAL** (Specify) Burial
**23b. DATE THEREOF** 3/13/62
**23c. NAME OF CEMETERY OR CREMATORY** Parkhawn Cemetery
**23d. LOCATION** (City, town or county) (State) Rockville, Maryland

**24 FUNERAL DIRECTOR'S SIGNATURE** Robert A. Pumphrey, Bethesda, Maryland
ADDRESS
**25a. REC'D BY REGISTRAR** DATE MAR 14 '62
**25b. REGISTRAR'S SIGNATURE** Carlton E. Krause

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

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03337

# MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
## CERTIFICATE OF DEATH

03330

**1. PLACE OF DEATH** a. COUNTY: Montgomery — MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring

c. LENGTH OF STAY IN 1b: 9 years

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 10,205 Douglas Avenue

**2. USUAL RESIDENCE** (Where deceased lived. If institution: Residence before admission) a. STATE: Maryland b. COUNTY: Montgomery

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 40 Silver Spring

d. STREET ADDRESS: 10,205 Douglas Avenue

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

**3. NAME OF DECEASED** (Type or print): First: Annie Middle: R. Last: Alsop

**4. DATE OF DEATH**: Month: March Day: 9 Year: 19 62

5. SEX: female

6. COLOR OR RACE: white

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Dec. 2, 1885

9. AGE (In years last birthday): 76 yrs. IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: own home

11. BIRTHPLACE (State or foreign country): Washington, D. C.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William Barrett

14. MOTHER'S MAIDEN NAME: Emile Gale

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): None

16. SOCIAL SECURITY NO.: ~~58~~ 579-30-2198

17. INFORMANT: Carl E. Alsop Address: 10205 Douglas Ave, S.S., Md.

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema

4 20.0

DUE TO (b) Arteriosclerotic Heart Disease

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c) /

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Pulmonary Tuberculosis 002.1

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) —

20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (~~this hospital~~) attended the deceased from July 23, 1961, to March 9, 1962, that (I) (we) last saw the deceased alive on March 9 1962 and that death occurred at 11:30 A.M., from the causes and on the date stated above.

22a. SIGNATURE: Edward J. Richards M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 3-9-62

22c. PHYSICIAN'S NAME (Type): Edward J. Richards

22d. ADDRESS: 10,110 Georgia Ave, Silver Spring, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 3-13-62

23c. NAME OF CEMETERY OR CREMATORY: Fort Lincoln Cemetery

23d. LOCATION (City, town, or county) (State): Prince George's Co., Maryland

24. FUNERAL DIRECTOR'S SIGNATURE: Raymond A. Pumphrey ADDRESS: 8434 Georgia Ave Warner E. Pumphrey, Inc. Silver Spring, Maryland

25a. REC'D BY REGISTRAR DATE MAR 13 '62

25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within [illegible] after death. Page 4 may be retained by hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) ISM 9/59

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03338 Item 7 Film G309 3/19/62 iwk 03331

## CERTIFICATE OF DEATH

**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 15M 9/60

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BETHESDA
c. LENGTH OF STAY IN 1b: 4½ days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): SUBURBAN

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: MONTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CHEVY CHASE
d. STREET ADDRESS: 4860 Chevy Chase Dr.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First HARRY Middle Dorsey Last AMISS
4. DATE OF DEATH: Month March Day 11 Year 1962
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ Married
8. DATE OF BIRTH: 2/21/1885
9. AGE (In years last birthday): 77 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): ~~Retxxx~~ Salesman-ret
10b. KIND OF BUSINESS OR INDUSTRY: Meat products
11. BIRTHPLACE (County & State, or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Edmund L. Amiss
14. MOTHER'S MAIDEN NAME: Angeline Greene
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) No (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: 577-07-4520
17. INFORMANT: Helen F. Amiss-wife-same 2d Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac Failure — INTERVAL BETWEEN ONSET AND DEATH: 5 hours
527.1
DUE TO (b) Auricular Fibrillation — Many Years
DUE TO (c) Frequent Pneumonias — " "
Emphysema — " "
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I **certify** that (I) (this hospital) attended the deceased from ....., 1932 to Mar 10, 1962 that (I) (we) last saw the deceased alive on Mar 10 1962 and that death occured at 5:30 AM from the causes and on the date stated above.

22a. SIGNATURE: Bradley D Hodgkins M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type): Bradley D. Hodgkins
22d. ADDRESS: 4413 Bradley Lane Chevy Chase Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 3/14/62
23c. NAME OF CEMETERY OR CREMATORY: Forest Oak Cemetery
23d. LOCATION (City, town or county) (State): Gaithersburg, Maryland

24 FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Robert A. Pumphrey, Bethesda, Maryland
25a. REC'D BY REGISTRAR DATE MAR 14 '62
25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03339 **CERTIFICATE OF DEATH** 03332

~~Item 23b Film G310 4/2/62 mh~~

**1. PLACE OF DEATH**
a. COUNTY: Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda (Rural)
c. LENGTH OF STAY IN 1b: 38 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): U. S. Naval Hospital

MARYLAND

**2. USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
a. STATE: South Carolina
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Folly Beach
d. STREET ADDRESS: 105 W. Erie Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First / Middle / Last: Louis Martin Anderson Jr.

4. DATE OF DEATH: Month / Day / Year: March 20, 19 62

5. SEX: Male
6. COLOR OR RACE: Caucasian
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: September 12, 1961
9. AGE (In years last birthday): yrs. IF UNDER 1 YEAR: Months 6 Days 9 IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Child
10b. KIND OF BUSINESS OR INDUSTRY: - - - - - -
11. BIRTHPLACE (County & State, or foreign country): South Carolina
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Louis Martin Anderson Sr.
14. MOTHER'S MAIDEN NAME: Carol Ann Cornelius
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
16. SOCIAL SECURITY NO. (If yes give war or dates of service): - - - - - -
17. INFORMANT: FATHER: Louis M. Anderson Sr., Address: Same as #2

**MEDICAL CERTIFICATION**

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Aspiration pneumonitis
DUE TO (b): Brain Damage
DUE TO (c): Hypoglycemia

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that ~~XX~~ (this hospital) attended the deceased from February 10, 19 62 to March 20, 19 62, that (I) (we) last saw the deceased alive on March 20, 19 62, and that death occured at 6:50 PM from the causes and on the date stated above

22a. SIGNATURE: Frederic A. Schulaner M.D.
22b. DATE SIGNED: March 21, 1962
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22c. PHYSICIAN'S NAME (Type): Frederic A. Schulaner LT MC USN
22d. ADDRESS: U. S. Naval Hospital, Bethesda, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Mar. 23, 1962
23c. NAME OF CEMETERY OR CREMATORY: Arlington National
23d. LOCATION (City, town or county) (State): Arlington, Virginia

24. FUNERAL DIRECTOR'S SIGNATURE: Robert A. Pumphrey Per L. Perry
Robert A. Pumphrey Funeral Home, 7557 Wisc. Ave., Bethesda, Md.

25a. REC'D BY REGISTRAR DATE MAR 23 '62
25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7,61

1171

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any de... necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AISME
5M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03340 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 03333

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
c. LENGTH OF STAY IN 1b: 16 years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 610 Pershing Drive

2. USUAL RESIDENCE (Where deceased I ved, If institution: Residence before adm.ssion)
a. STATE: Maryland
b. COUNTY: Mont.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 29 Silver Spring
d. STREET ADDRESS: 610 Pershing Drive
e. IS RESIDENCE ON A FARM? YES [ ] NO [X]

3. NAME OF DECEASED (Type or print): First: George — Middle: (nmi) — Last: Argerake

4. DATE OF DEATH: Month: March — Day: 6 — Year: 19 62

5. SEX: male
6. COLOR OR RACE: white
7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: 3/14/1897
9. AGE (In years last birthday): 64 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Gro. Clerk
10b. KIND OF BUSINESS OR INDUSTRY: N&B Delicatessen
11. BIRTHPLACE (State or foreign country): ~~Greech~~ Greece
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Edward Argerake
14. MOTHER'S MAIDEN NAME: Maria Chagaroulis

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No — (If yes give war or dates of service): None
16. SOCIAL SECURITY NO.: yes
17. INFORMANT: Patricia J. Argerake 610 Pershing Dr, S.S., Md. — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Peracerdial Tamponade — INTERVAL BETWEEN ONSET AND DEATH: sudden

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. — DUE TO (b) Rup. of heart — DUE TO (c) Myocardial infarction — 7 to 10 das.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES [X] NO [ ]

20a. EXTERNAL CAUSE WAS PRIMARY [ ] or CONTRIBUTING [ ] CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.): Auto Accident
20c. TIME OF INJURY: Hour 5:00 XX p.m. — Month, Day, Year: Sept. 1960
20d. INJURY OCCURRED: While at work [X] — Not While at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): XXX. Highway
20f. (City or town): Wash. — (County) — (State): D.C.

21. I certify that I took charge of the remains described above, held an Autopsy [X], Inspection [ ], Inquiry [ ], and in my opinion death resulted from. Natural causes [X], Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE: Frank J. Broschart M.D
EXAMINER'S NAME (Type): Frank J. Broschart
CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]
Address (Street, city, town, or county)
DATE SIGNED: March 7, 1962

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 3-8-62
22c. NAME OF CEMETERY OR CREMATORY: Glenwood Cemetery
22d. LOCATION (City, town, or country): Washington, D.C. — (State)

23. FUNERAL DIRECTOR: Warner E. Pumphrey, Inc. — ADDRESS: Raymond A. Zisko 8434 Georgia Ave. Silver Spring, Maryland
24a. REC'D BY REGISTRAR: DATE MAR 8 '62
24b. REGISTRAR'S SIGNATURE: [illegible]

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# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

03341 Items 1 & 2 Film 0308 3/12/62 iwk 03334

**1. PLACE OF DEATH**
a. COUNTY: Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ~~Rockville~~ Rockville
c. LENGTH OF STAY IN 1b: MARYLAND
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Manor Club Estates

**2. USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ~~Rockville~~ Rockville,
d. STREET ADDRESS: Carrolton & Norbeck / Manor Club Estates
IS RESIDENCE ON A FARM? YES ☐ NO ☒

**3. NAME OF DECEASED** (Type or print): First Charlotte, Middle Louise, Last Ballard

**4. DATE OF DEATH**: Month 3, Day 3, Year 1962

**5. SEX**: Female
**6. COLOR OR RACE**: White
**7. MARRIED** ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐
**8. DATE OF BIRTH**: July 19, 1888
**9. AGE** (In years last birthday): 73 yrs. IF UNDER 1 YEAR: Months / Days; IF UNDER 24 HRS.: Hours / Min.

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): Clerk
**10b. KIND OF BUSINESS OR INDUSTRY**: Real Estate
**11. BIRTHPLACE** (County & State, or foreign country): Maryland
**12. CITIZEN OF WHAT COUNTRY?**: U.S.A.

**13. FATHER'S NAME**: George H. Langhenry
**14. MOTHER'S MAIDEN NAME**: Amelia S. Lambert

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unknown) (If yes give war or dates of service):
**16. SOCIAL SECURITY NO.**:
**17. INFORMANT**: Burton H. Langhenry Address: Manor Club Estates, Rockville Md.

MEDICAL CERTIFICATION

**18. CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Generalized Carcinomatosis — INTERVAL BETWEEN ONSET AND DEATH: 1 Month
DUE TO
(b): Carcinoma of Cecum — 6 months
DUE TO
(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

**19. WAS AUTOPSY PERFORMED?** YES ☐ NO ☒

**20a. ACCIDENT WAS UNDERLYING** ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)
**20b. DESCRIBE HOW INJURY OCCURED.** (Enter nature of injury in Part I or Part II of item 18.)
**20c. TIME OF INJURY** Hour a.m. p.m. Month, Day, Year 19
**20d. INJURY OCCURRED** While at work ☐ Not While at work ☐
**20e. PLACE OF INJURY** (Home, farm, factory, street, office bldg., etc.)
**20f.** (City or town) (County) (State)

**21. I certify** that (I) ~~(this hospital)~~ attended the deceased from 1-29, 1962 to 3-3, 1962, that (I) ~~(we)~~ last saw the deceased alive on 2-28-, 1962 and that death occured at 4 A.M. from the causes and on the date stated above.

**22a. SIGNATURE**: C. Roger Kurtz
**22b. DATE SIGNED**: 3-3-62
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
**22c. PHYSICIAN'S NAME** (Type): C. Roger Kurtz, M.D.
**22d. ADDRESS**: 3701 Connecticut Ave NW. Wash 8, D.C.

**23a. BURIAL, CREMATION, REMOVAL** (Specify): Burial
**23b. DATE THEREOF**: 3-6-62
**23c. NAME OF CEMETERY OR CREMATORY**: Fort Lincoln Cemetery
**23d. LOCATION** (City, town or county) (State): Bladensburg Maryland

**24. FUNERAL DIRECTOR'S SIGNATURE**: Deal Funeral Home
ADDRESS: 4812 Ga. Ave., N.W., Wash., D.C.
**25a. REC'D BY REGISTRAR** DATE: MAR 8 '62
**25b. REGISTRAR'S SIGNATURE**: [illegible]

**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be exe[illegible] 24 hours after death. Page 4 may be retained by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03342

# CERTIFICATE OF DEATH

Reg. Dist. No. 03335

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BETHESDA
c. LENGTH OF STAY IN 1b: 7 DAYS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: SUBURBAN HOSP.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MD
b. COUNTY: MONTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): KENSINGTON
d. STREET ADDRESS: 3908 BALTIMORE ST.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First WILLIAM Middle L. Last BARKER

4. DATE OF DEATH: Month March Day 11 Year 1962

5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 2-28-76
9. AGE (In years last birthday): 86 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS: Hours Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED
10b. KIND OF BUSINESS OR INDUSTRY: Millwright
11. BIRTHPLACE (State or foreign country): WEST VIRGINIA
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: ZACKWELL MORGAN BARKER
14. MOTHER'S MAIDEN NAME: MARY ELLEN RIGGS

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service): NONE
16. SOCIAL SECURITY NO: 235-12-7287
17. INFORMANT: DAUGHTER MRS MILDRED HARMAN Address: S/A

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Respiratory Failure — INTERVAL BETWEEN ONSET AND DEATH: 24 hrs
DUE TO (b) Uremia — 4 days
DUE TO (c) Pyelitis and Prostatitis — 4 month

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from DEC, 1955 to 3/11, 1962 That I last saw the deceased alive on 3/11, 1962, and that death occurred at 2 30 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Frank Y Jiggers Jr. M.D. ADDRESS (Street, city or town, state): 5707 Wisconsin Ave DATE SIGNED: 3/11/62
PHYSICIAN'S NAME (Type): FRANK Y. SIGGERS JR. Chevy Chase 15, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 3-13-62
22c. NAME OF CEMETERY OR CREMATORY: Colesville Cemetery
22d. LOCATION (City, town, or county) (State): Colesville Montgomery Co, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Warner E. Pumphrey, Inc. ADDRESS: 8434 Georgia Ave Silver Spring, Maryland
24a. REC'D BY REGISTRAR DATE MAR 14 '62
24b. REGISTRAR'S SIGNATURE: S. Thomas

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03343 **CERTIFICATE OF DEATH** 03336

1. PLACE OF DEATH
a. COUNTY: Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 12hrs. 25mins.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Suburban

MARYLAND

2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)
a. STATE: D.C.
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington
d. STREET ADDRESS: 1536 Independence Ave. S.E.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

47X-3

3. NAME OF DECEASED (Type or print): First: Joseph Middle: Henry Last: Barnes
4. DATE OF DEATH: Month: March Day: 31 Year: 1962
5. SEX: Male
6. COLOR OR RACE: Negro
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 2/18/17
9. AGE (In years last birthday): 45 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Porter
10b. KIND OF BUSINESS OR INDUSTRY: Drug Co.
11. BIRTHPLACE (County & State, or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Frances Barnes
14. MOTHER'S MAIDEN NAME: Frances Mack
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes give war or dates of service): no
16. SOCIAL SECURITY NO.:
17. INFORMANT: Chloe Barnes Address: Same As Above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) | STATUS ASTHMATICUS | 24 hrs |
| DUE TO (b) | ADRENAL INSUFFICIENCY | 12 hr. |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) | | |

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 3/31/62, 19..., to 3/31/62 19..., that (I) (~~we~~) last saw the deceased alive on 3/31/62 19..., and that death occured at 6 p.m., from the causes and on the date stated above.

22a. SIGNATURE: John E. Everett M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 4/1/62
22c. PHYSICIAN'S NAME (Type): JOHN E. EVERETT
22d. ADDRESS: 9400 Conn Ave Kensington Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 4/4/1962
23c. NAME OF CEMETERY OR CREMATORY: Lincoln
23d. LOCATION (City, town or county) (State): Suitland, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE: William R. Rishon
ADDRESS: W. Ernest Jarvis Co., Inc. 1432 You Street, N.W.
25a. REC'D BY REGISTRAR DATE: APR 5 '62
25b. REGISTRAR'S SIGNATURE: Arthur S. Kime

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Rule 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health priar to burial, cremation, or removal, and in any event, within 72 hours after death

VR A15 (4)
15M 9/59

# MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

03344

## CERTIFICATE OF DEATH

03337

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not a hospital, give street address) OR INSTITUTION: 14511 Colesville Rd. Marilea Nursing Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
d. STREET ADDRESS: 901 Snider Lane
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First / Middle / Last: Alpha L. Beck
4. DATE OF DEATH: Month / Day / Year: March 26, 1962
5. SEX: female
6. COLOR OR RACE: white
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 12/29/87
9. AGE (In years last birthday): 74 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): New Jersey
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Elsworth M. Eastwood
14. MOTHER'S MAIDEN NAME: Dena F. Huffman
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 579-48-8280
17. INFORMANT: Edward R. Beck — Address: same as #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) | Acute myocardial infarct | 30 days |
| DUE TO (b) | Chronic myocarditis | 3 mos |
| DUE TO (c) | | |

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 422.7

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Month, Day, Year — Hour a. m. p. m. — 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.):
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from March 2, 1962 to March 26, 1962 that (I) (we) last saw the deceased alive on March 23, 1962 and that death occurred at 4:00 P.M. from the causes and on the date stated above.

22a. SIGNATURE: John S. Rogers, M.D.
ATTENDING PHYS ☐ MED DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: March 26, 1962
22c. PHYSICIAN'S NAME (Type): John S. Rogers
22d. ADDRESS: 1919 Seminary Rd. Silver Spring, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): burial
23b. DATE THEREOF: 3/29/62
23c. NAME OF CEMETERY OR CREMATORY: Rock Creek Cemetery
23d. LOCATION (City, town, or county) (State): Washington, D.C.

24. FUNERAL DIRECTOR'S SIGNATURE: The S.H. Hines Company
ADDRESS: 2901 14th St. N.W. Washington 9, D.C.
25a. REC'D BY REGISTRAR DATE: MAR 28 '62
25b. REGISTRAR'S SIGNATURE: C. Ann L. Hines

# MARYLAND STATE DEPARTMENT OF HEALTH

**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

03345 **CERTIFICATE OF DEATH** 03338

**1. PLACE OF DEATH**
a. COUNTY: Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN MARYLAND: 60 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): The Clinical Center, Bethesda 14, Md.

**2. USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): (Rural) Flintstone
d. STREET ADDRESS: Route #2
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: Walter; Middle: Wayne; Last: Bender
4. DATE OF DEATH: Month: March; Day: 26; Year: 1962
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: 20 October 1938
9. AGE (In years last birthday): 23 yrs. IF UNDER 1 YEAR: Months / Days; IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer
10b. KIND OF BUSINESS OR INDUSTRY: Farm
11. BIRTHPLACE (County & State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Walter L. Bender
14. MOTHER'S MAIDEN NAME: Eva Wilson
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT: The Medical Record, Address: The Clinical Center, Bethesda 14, Maryland

**18. CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Hodgkins Disease — INTERVAL BETWEEN ONSET AND DEATH: 2 years

DUE TO (b)

DUE TO (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

201 X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES [X] NO [ ]

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work [ ] Not While at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I (this hospital) attended the deceased from Jan. 25, 1962, to March 26, 1962, that I (we) last saw the deceased alive on March 26, 1962, and that death occured at 7:15 A.M. from the causes and on the date stated above.

22a. SIGNATURE: Michael Field M.D.
ATTENDING PHYS. [ ] MED. DIRECTOR [ ] STAFF PHYS. [X]
22b. DATE SIGNED: March 26, 1962
22c. PHYSICIAN'S NAME (Type): Michael Field, M.D.
22d. ADDRESS: The Clinical Center, National Institutes of Health, Bethesda 14, Md. (State)

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 3/29/62
23c. NAME OF CEMETERY OR CREMATORY: Sunset Memorial Park
23d. LOCATION (City, town or county): Cumberland, Maryland

24 FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: John J. Hafer, Cumberland, Maryland

25a. REC'D BY REGISTRAR: DATE MAR 28 '62
25b. REGISTRAR'S SIGNATURE: [illegible]

**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 is retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03346 **CERTIFICATE OF DEATH** 03339

Item 8 Film 0308 3/9/62 mb

**1. PLACE OF DEATH**
a. COUNTY: Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: 1 day
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Washington Sanitarium + Hospital

MARYLAND

**2. USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 32 Silver Spring
d. STREET ADDRESS: 309 Belton Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

**3. NAME OF** [redacted] (Type or print): First: Mary; Middle: ; Last: Berkowitz

**4. DATE OF DEATH**: Month: 3; Day: 5; Year: 1962

**5. SEX**: Female
**6. COLOR OR RACE**: White
**7. MARRIED** ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐
**8. DATE OF BIRTH**: 12-17-1882
**9. AGE** (In years last birthday): 79 yrs. IF UNDER 1 YEAR: Months / Days; IF UNDER 24 HRS.: Hours / Min.

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): H.W. CORSETIERRE RETIRED
**10b. KIND OF BUSINESS OR INDUSTRY**:
**11. BIRTHPLACE** (County & State, or foreign country): Poland
**12. CITIZEN OF WHAT COUNTRY?**: NON CITIZEN

**13. FATHER'S NAME**: JEROME LEVINSON
**14. MOTHER'S MAIDEN NAME**: DEBORAH

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unkown): NO (If yes give wars or dates of service)
**16. SOCIAL SECURITY NO.**: 102-03-4248
**17. INFORMANT**: GEORGE BLOOM Address: 309 BELTON Rd. SS Md.

**18. CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c))

PART I. DEATH WAS CAUSED BY:

| | | Interval between onset and death |
|---|---|---|
| IMMEDIATE CAUSE (a) | Pulmonary Edema | 12 Hours |
| DUE TO (b) | Congestive Heart Failure | Unknown |
| DUE TO (c) | Hyper Tensive Heart Disease | Unknown |

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): 1) Gastrointestinal Bleeding 2) Bronchopneumonia 3)

**19. WAS AUTOPSY PERFORMED?** YES ☐ NO ☒

**20a. ACCIDENT WAS UNDERLYING** ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)
**20b. DESCRIBE HOW INJURY OCCURED** (Enter nature of injury in Part I or Part II of item 18.)
**20c. TIME OF INJURY** Hour a.m. p.m. Month, Day, Year 19
**20d. INJURY OCCURRED** While at work ☐ Not While at work ☐
**20e. PLACE OF INJURY** (Home, farm, factory, street, office bldg., etc.)
**20f.** (City or town) (County) (State)

**21. I certify** that (I) (this hospital) attended the deceased from March 4, 1962 to March 5, 1962 that (I) (~~we~~) last saw the deceased alive on March 5, 1962, and that death occured at 3:15 p.m. from the causes and on the date stated above.

**22a. SIGNATURE**: Stuart L. Nelson M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐
**22b. DATE SIGNED**: 3-5-62
**22c. PHYSICIAN'S NAME** (Type): STUART L. NELSON, M.D.
**22d. ADDRESS**: 7600 CARROLL AVE. TAK. PK. MD

**23a. BURIAL, CREMATION, REMOVAL** (Specify): BURIAL
**23b. DATE THEREOF**: MARCH 6, 1962
**23c. NAME OF CEMETERY OR CREMATORY**: ST. HEBRON CEMETERY
**23d. LOCATION** (City, town or county): FLUSHING L.I. (State): NY

**24. FUNERAL DIRECTOR'S SIGNATURE**: Bernard Bluggenthal Sons
ADDRESS: 3501-14th St NW

**25a. REC'D BY REGISTRAR** DATE MAR 7 '62
**25b. REGISTRAR'S SIGNATURE**: Lewis S. Thomas

MEDICAL CERTIFICATION

**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
15M 7/61

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M

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03347 **CERTIFICATE OF DEATH** 03340

Item 2 Film 6310 1/5/62

**1. PLACE OF DEATH**
a. COUNTY: MONTGOMERY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 5 yrs
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Resmor Hospital

**2. USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
a. STATE: MARYLAND (Va.)
b. COUNTY: MONTGOMERY
c. CITY OR TOWN (If outside corporate limit write RURAL and give nearest town): Bethesda (West Point)
d. STREET ADDRESS: 1517 Beverly Lane
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

**3. NAME OF DECEASED** (Type or print): First MARY, Middle ELIZABETH, Last BESWICK

**4. DATE OF DEATH**: Month 3, Day 26, Year 1962

**5. SEX**: FEMALE
**6. COLOR OR RACE**: W
**7. MARRIED** ☐ **NEVER MARRIED** ☐ **WIDOWED** ☑ **DIVORCED** ☐
**8. DATE OF BIRTH**: 11-28-1881
**9. AGE** (In years last birthday): 80 yrs. | IF UNDER 1 YEAR: Months, Days | IF UNDER 24 HRS.: Hours, Min.

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): Housewife
**10b. KIND OF BUSINESS OR INDUSTRY**: —
**11. BIRTHPLACE** (County & State, or foreign country): ENGLAND
**12. CITIZEN OF WHAT COUNTRY?**: U.S.

**13. FATHER'S NAME**: William Richard Webb
**14. MOTHER'S MAIDEN NAME**: Mary Elizabeth Dutton

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unknown) (If yes, give war or dates of service): No
**16. SOCIAL SECURITY NO.**: Unknown
**17. INFORMANT**: HERBERT G. BESWICK, Address

**MEDICAL CERTIFICATION**

**18. CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CIRCULATORY COLLAPSE — INTERVAL BETWEEN ONSET AND DEATH: 2 MINUTES
DUE TO (b): HEART FAILURE (? INFARCTION) — 1 DAY
DUE TO (c): ARTERIOSCLEROTIC HEART DISEASE — 20+ YRS

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): RHEUMATOID ARTHRITIS, EPILEPSY

**19. WAS AUTOPSY PERFORMED?** YES ☐ NO ☑

**20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER) ☐
**20b. DESCRIBE HOW INJURY OCCURED.** (Enter nature of injury in Part I or Part II of item 18.)
**20c. TIME OF INJURY** Month, Day, Year — Hour a.m. p.m. 19
**20d. INJURY OCCURRED** While at work ☐ Not While at work ☐
**20e. PLACE OF INJURY** (Home, farm, factory, street, office bldg., etc.)
**20f.** (City or town) (County) (State)

**21. I certify** that (I) (this hospital) attended the deceased from 12/22/57, 19.., to 3/26, 19.., that (I) (we) last saw the deceased alive on 3/26, 1962, and that death occured at 7:15 P.M. from the causes and on the date stated above.

**22a. SIGNATURE**: Charles Savarese, M.D.
ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐
**22b. DATE SIGNED**: 3/26/62
**22c. PHYSICIAN'S NAME** (Type): CHARLES J. SAVARESE, MD
**22d. ADDRESS**: 4890 BATTERY LA. BETHESDA, MD

**23a. BURIAL, CREMATION, REMOVAL** (Specify): Burial
**23b. DATE THEREOF**: 3/29/62
**23c. NAME OF CEMETERY OR CREMATORY**: Hopewell Cemetery
**23d. LOCATION** (City, town or county) (State): Hopewell, Virginia

**24. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS**: Robert A. Pumphrey, Bethesda, Maryland

**25a. REC'D BY REGISTRAR** DATE MAR 30 '62
**25b. REGISTRAR'S SIGNATURE**: Clifton S. Hawes

**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03348

## CERTIFICATE OF DEATH

Reg. Dist. No. 03341

**1. PLACE OF DEATH**
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
c. LENGTH OF STAY IN 1b: 10 years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 407 University Blvd, West

**2. USUAL RESIDENCE** (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
d. STREET ADDRESS: 407 University Blvd West
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

**3. NAME OF DECEASED** (Type or print): First: Kathleen — Middle: (NMI) — Last: Bettinger

**4. DATE OF DEATH**: Month: March — Day: 30 — Year: 1962

**5. SEX**: Female

**6. COLOR OR RACE**: Caucasian

**7. MARRIED** ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

**8. DATE OF BIRTH**: Sept 11, 1923

**9. AGE** (In years last birthday): 38 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): Housewife

**10b. KIND OF BUSINESS OR INDUSTRY**: Own home

**11. BIRTHPLACE** (State or foreign country): New York

**12. CITIZEN OF WHAT COUNTRY?**: U.S.A.

**13. FATHER'S NAME**: Joseph Bloomer

**14. MOTHER'S MAIDEN NAME**: Catherine V. Finnan

**15. WAS DECEASED EVER IN U. S. ARMED FORCES?** (Yes, no, or unknown): No — (If yes, give war or dates of service): None

**16. SOCIAL SECURITY NO**: 101 14 5048

**INFORMANT**: Catherine Finnan — Address: 407 University Blvd, W Silver Spring, Md.

**MEDICAL CERTIFICATION**

**18. CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure — INTERVAL BETWEEN ONSET AND DEATH: 1 hr.

DUE TO (b) Liver failure — 1 mo

DUE TO (c) Metastatic Carcinoma of Breast — 3 mo

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Rt. mastectomy April 1960.

**19. WAS AUTOPSY PERFORMED?** YES ☐ NO ☒

**20a. ACCIDENT WAS UNDERLYING** ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

**20b. DESCRIBE HOW INJURY OCCURRED** (Enter nature of injury in Part I or Part II of item 18)

**20c. TIME OF INJURY** Month, Day, Year — Hour a.m. p.m. — 19

**20d. INJURY OCCURRED** While at work ☐ Not while at work ☐

**20e. PLACE OF INJURY** (Home, farm, factory, street, office bldg., etc.)

**20f.** (City or town) (County) (State)

**21. I certify** that I attended the deceased from January, 1953, to March 30, 1962 that I last saw the deceased alive on March 29, 1962, and that death occurred at 12:30 AM, from the causes and on the date stated above.

ACTUAL SIGNATURE: Raymond Bradshaw, Jr. M.D. — ADDRESS (Street, city or town, state): 345 University Blvd. W. — DATE SIGNED: 3/30/62

PHYSICIAN'S NAME (Type): Raymond Bradshaw, Jr. — Silver Spring, Md

**22a. BURIAL CREMATION REMOVAL** (Specify): Burial

**22b. DATE THEREOF**: 4-2-62

**22c. NAME OF CEMETERY OR CREMATORY**: Gate of Heaven Cemetery

**22d. LOCATION** (City, town, or county) (State): Silver Spring, Montgomery Co. Md.

**23. FUNERAL DIRECTOR'S SIGNATURE**: Raymond A. Zinn — ADDRESS: 8434 Georgia Ave. Silver Spring, Maryland — Warner E. Pumphrey, Inc.

**24a. REC'D BY REGISTRAR** DATE: APR 2 '62

**24b. REGISTRAR'S SIGNATURE**: Curtis S. Kraus

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

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FOR STATE HEALTH DEPT.

M

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03349 03342

1. PLACE OF DEATH
a. COUNTY: Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rockville
c. LENGTH OF STAY IN Md: MARYLAND
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 203 Croyden Ave

2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)
a. STATE: Md
b. COUNTY: Mont
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 19 Rockville
d. STREET ADDRESS: 203 Croyden Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): Robert Thompson Blanke Jr.
4. DATE OF DEATH: Mar 29 1962
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒
8. DATE OF BIRTH: 7-6-08
9. AGE (In years last birthday): 53 yrs. IF UNDER 1 YEAR: Months, Days. IF UNDER 24 HRS.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): T.V. Repair
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Lynchburg, Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Robert T. Banks
14. MOTHER'S MAIDEN NAME: Blanche ~~Frances~~ Lazenby
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No
16. SOCIAL SECURITY NO: 719-05-2664
17. INFORMANT: Robert T. Blanke III — Address: 5201 Tordyce Place -Bethesda, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage + laceration
DUE TO (b) Shot gun wound Thru skull
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)
INTERVAL BETWEEN ONSET AND DEATH: sudden
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.) Self inflicted shot gun wound Thru skull
20c. TIME OF INJURY: Hour 7 a.m. p.m. Month, Day, Year 3-29 1962
20d. INJURY OCCURRED While at work ☐ Not While at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): home
20f. (City or town): Rockville (County): Monty (State): Md

21. I **certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☒, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Frank J. Broschart M.D.
EXAMINER'S NAME (Type): FRANK J. BROSCHART
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 3-29-62
Address (Street, city, town, or county)

22a. BURIAL, CREMATION, REMOVAL (Specify): Bur-Transit
22b. DATE THEREOF: 4/2/62
22c. NAME OF CEMETERY OR CREMATORY: [redacted] Springhill
22d. LOCATION (City, town, or county): Lynchburg, Virginia (State):
23. FUNERAL DIRECTOR: Tyson Meeler Funeral Home-1331 E. Montg. Ave. Rockville, Maryland
24a. REC'D BY REGISTRAR: DATE APR 3 '62
24b. REGISTRAR'S SIGNATURE: Arthur S. Thomas

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any [illegible] necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03350 **CERTIFICATE OF DEATH** 03343

item 23b, Film G509 5/15/62 iwk

**1. PLACE OF DEATH**
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda (Rural)
c. LENGTH OF STAY IN 1b: 122 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): U. S. Naval Hospital

**2. USUAL RESIDENCE** (Where deceased lived, If Institution, Residence before admission)
a. STATE: California
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): San Diego
d. STREET ADDRESS: 4231 Santa Cruz Avenue
e. IS RESIDENCE ON A FARM? YES [ ] NO [X]

**3. NAME OF DECEASED** (Type or print): First: Esther — Middle: Lillian — Last: Bogenholm

**4. DATE OF DEATH**: Month: March — Day: 8, — Year: 1962

**5. SEX**: Female

**6. COLOR OR RACE**: Caucasian

**7. MARRIED** [X] **NEVER MARRIED** [ ] **WIDOWED** [ ] **DIVORCED** [ ]

**8. DATE OF BIRTH**: January 20, 1907

**9. AGE** (In years last birthday): 55 yrs. — IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS.: Hours: — Min.:

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): Housewife

**10b. KIND OF BUSINESS OR INDUSTRY**:

**11. BIRTHPLACE** (County & State, or foreign country): San Diego, California

**12. CITIZEN OF WHAT COUNTRY?**: USA

**13. FATHER'S NAME**: John P. Feeny

**14. MOTHER'S MAIDEN NAME**: Mary A. Hachatt

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unkown): No

**16. SOCIAL SECURITY NO.** (If yes give war or dates of service): - - - - -

**17. INFORMANT** — Address: HUSBAND: Wilbor T. Bogenholm, Same as #2

**MEDICAL CERTIFICATION**

**18. CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c))

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) BRONCHIPNEUMONIA — INTERVAL BETWEEN ONSET AND DEATH: 24 HOURS
DUE TO (b) JAKOB-CREUTZFELDT SYNDROME — 1 YR.
DUE TO (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

**19. WAS AUTOPSY PERFORMED?** YES [X] NO [ ]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work [ ] Not While at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (X (this hospital) attended the deceased from Nov. 6, 19.61 to March 8, 19.62, that (I) (we) last saw the deceased alive on March 8, 1962, and that death occured at 4:08PM from the causes and on the date stated above.

22a. SIGNATURE: John W. Brackett Jr. MD — ATTENDING PHYS. [ ] MED. DIRECTOR [ ] STAFF PHYS [X]

22b. DATE SIGNED: March 9, 1962

22c. PHYSICIAN'S NAME (Type): JOHN W. BRACKETT JR., LT MC USN

22d. ADDRESS: U. S. Naval Hospital, Bethesda, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 3/11/62

23c. NAME OF CEMETERY OR CREMATORY: Holy Cross

23d. LOCATION (City, town or county) (State): San Diego, California

24 FUNERAL DIRECTOR'S SIGNATURE: Robert A. Pumphrey — Bethesda, Md.
Robert A. Pumphrey Funeral Home, 7557 Wisc. Ave.

25a. REC'D BY REGISTRAR DATE: MAR 12 '62

25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
1SM 7/61

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03351 **CERTIFICATE OF DEATH** 03344

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CHEVY CHASE
c. LENGTH OF STAY IN this place: 2 YEARS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 4306 Curtis Road

2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)
a. STATE: MARYLAND
b. COUNTY: MONTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CHEVY CHASE
d. STREET ADDRESS: 4306 CURTIS ROAD
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First CHRISTINA Middle ANNA Last BOSE

4. DATE OF DEATH: Month 3 Day 12 Year 1962

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐

8. DATE OF BIRTH: FEB 3, 1873

9. AGE (In years last birthday): 89 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): WOODRIDGE N.J.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: JULIUS SANS

14. MOTHER'S MAIDEN NAME: BARBARA ANN VOLKER

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes give war or dates of service):

16. SOCIAL SECURITY NO.: —

17. INFORMANT: AGNES M. HARRIS Address: MCDANIEL, MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHIAL PNEUMONIA — INTERVAL BETWEEN ONSET AND DEATH: 3 days

DUE TO (b) PULMONARY EMPYSEMA & FIBROSIS — 15 YEARS

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): ARTERIAL OCCLUSION LEFT POPLITEAL

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (i) (this hospital) attended the deceased from JUNE 30, 1959, to MARCH 12, 1962 that (I) (we) last saw the deceased alive on MARCH 11, 1962 and that death occured at ... P.M. from the causes and on the date stated above.

22a. SIGNATURE: Robert N. Coale M.D.

ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: March 12, 1962

22c. PHYSICIAN'S NAME (Type): ROBERT N. COALE

22d. ADDRESS: 4429 BRADLEY LANE, CHEVY CHASE, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial-Transit 3/15/62

23b. DATE THEREOF

23c. NAME OF CEMETERY OR CREMATORY: Greenwood Cemetery

23d. LOCATION (City, town or county) (State): Brooklyn, New York

24 FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Robert A. Pumphrey, Bethesda, Maryland

25a. REC'D BY REGISTRAR DATE MAR 15 '62

25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
1SM 7/61

1

FOR STATE HEALTH DEPT.

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03352 03345

1. PLACE OF DEATH
a. COUNTY: Montgomery MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Washington Grove
c. LENGTH OF STAY IN 1b: 14 yr
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 416 5th Ave

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Md
b. COUNTY: Montg
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Washington Grove
d. STREET ADDRESS: 416 5th Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): Edwin Hinton Bowling (First, Middle, Last)

4. DATE OF DEATH: Mar 13 1962 (Month, Day, Year)

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 7-3-1900
9. AGE (in years last birthday): 61 yrs. IF UNDER 1 YEAR: Months, Days; IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Merchant
10b. KIND OF BUSINESS OR INDUSTRY: retired
11. BIRTHPLACE (State or foreign country): N. C.
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: E. H. Bowling
14. MOTHER'S MAIDEN NAME: Mimi Jackson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown)
16. SOCIAL SECURITY NO. (If yes give war or dates of service)
17. INFORMANT: Augusta Bowling (wife) Address: Item 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: sudden
4 JON
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Frank J. Broschart M.D.
EXAMINER'S NAME (Type): FRANK J. BROSCHART
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county):
DATE SIGNED: Mar 13-62

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 3/15/62
22c. NAME OF CEMETERY OR CREMATORY: Arlington Nat. Cem.
22d. LOCATION (City, town, or county) (State): Arlington Co Va

23. FUNERAL DIRECTOR: Chas. Chase Funeral Home
ADDRESS: 5193 Georgia Ave Wash. 16 D.C.
Rep. J. Pettis
24a. REC'D BY REGISTRAR: MAR 15 '62
24b. REGISTRAR'S SIGNATURE: Chas. S. Kraus

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any [illegible] necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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5M 9/60

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FOR STATE HEALTH DEPT.

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03353 03346

1. PLACE OF DEATH
a. COUNTY: Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: MARYLAND
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 4405 East West Hwy. Apt 210

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Md
b. COUNTY: Monty
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
d. STREET ADDRESS: 4405 East West Hwy (Apt 210)
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Douglas; Middle: Adair; Last: Boykin

4. DATE OF DEATH: Month: March; Day: 5; Year: 1962

5. SEX: male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 12-17-09

9. AGE (In years last birthday): 52 yrs. IF UNDER 1 YEAR: Months: 2; Days: 18 IF UNDER 24 HRS.: Hours: ; Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Policeman

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Ala.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Clarence Boykin

14. MOTHER'S MAIDEN NAME: Mary Adair

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): ~~No~~ Yes (If yes give war or dates of service): WW 2

16. SOCIAL SECURITY NO.: Unknown

17. INFORMANT: Dorothy Boykin (wife) Address: Stem 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Thoracic hemorrhage
DUE TO (b): Shot gun wound in left chest (heart)
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: Sudden

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.): Self inflicted shot gun wound (12 gauge)

20c. TIME OF INJURY: Hour 7 p.m. Month, Day, Year: 3-5 1962

20d. INJURY OCCURRED While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home

20f. (City or town): Bethesda (County): Monty (State): Md

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from. Natural causes ☐, Accident ☐, Suicide ☒, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Frank J. Broschart M.D.

EXAMINER'S NAME (Type): FRANK J. Broschard

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county):

DATE SIGNED: 3-5-62

22a. BURIAL, CREMATION, REMOVAL (Specify): Bremation

22b. DATE THEREOF: 3/7/62

22c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Crematory

22d. LOCATION (City, town, or country): Suitland, Maryland (State):

23. FUNERAL DIRECTOR: Robert A. Pumphrey, Bethesda, Maryland

ADDRESS:

24a. REC'D BY REGISTRAR DATE: MAR 9 '62

24b. REGISTRAR'S SIGNATURE: Arthur S. Thomas

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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VS. AIIME
SM 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03354 **CERTIFICATE OF DEATH** 03347

1. PLACE OF DEATH
a. COUNTY: Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN MARYLAND: 5 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Suburban

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: D.C.
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington
d. STREET ADDRESS: 5401 Galena Pl., N.W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Daniel Middle: A. Last: Boyle
4. DATE OF DEATH: Month: March Day: 19 Year: 1962
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 9/7/87
9. AGE (In years last birthday): 74 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): D.C.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Thomas Boyle
14. MOTHER'S MAIDEN NAME: Elizabeth Casey
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): no (If yes give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT: Elva Boyle, wife Address: same as above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSE BY: IMMEDIATE CAUSE (a) RENAL FAILURE UREMIA — INTERVAL BETWEEN ONSET AND DEATH: 5 DAYS

DUE TO (b) RUPTURED APPENDIX with PERITONITIS — 7 DAYS

DUE TO (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 550

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Dec 19 54 to March 19 62 that (I) (we) last saw the deceased alive on 3/19 1962, and that death occured at 12 M, from the causes and on the date stated above.

22a. SIGNATURE: Leo I Donovan M.D.
22b. DATE SIGNED: 3/19/62
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22c. PHYSICIAN'S NAME (Type): LEO I DONOVAN MD
22d. ADDRESS: 8215 WISC AVE BETH 14 MD

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: MAR. 22, 1962
23c. NAME OF CEMETERY OR CREMATORY: MT. OLIVET CEMETERY
23d. LOCATION (City, town or county): WASHINGTON (State) D.C.
24. FUNERAL DIRECTOR'S SIGNATURE: H. Don. DeVol ADDRESS: 2224-Wis. Ave
25a. REC'D BY REGISTRAR DATE
25b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03355 **CERTIFICATE OF DEATH** 03348

1. PLACE OF DEATH
a. COUNTY: Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN MARYLAND: 49 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): The Clinical Center, Bethesda 4, Md.

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Virginia
b. COUNTY: Arlington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Arlington
d. STREET ADDRESS: 1309 South Taylor Street
e. IS RESIDENCE ON A FARM? YES [ ] NO [X]

3. NAME OF DECEASED (Type or print): First: Harold; Middle: Chester; Last: Braun
4. DATE OF DEATH: Month: March; Day: 23; Year: 1962
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: 24 June 1903
9. AGE (In years at last birthday): 59 yrs. IF UNDER 1 YEAR: Months / Days. IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Service Manager
10b. KIND OF BUSINESS OR INDUSTRY: Department Store
11. BIRTHPLACE (County & State, or foreign country): Pennsylvania
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: George Braun
14. MOTHER'S MAIDEN NAME: Josephine Slater
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: 173-12-6576
17. INFORMANT: The Medical Record, Address: The Clinical Center, Bethesda 14, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Perforated Duodenal Ulcer with peritonitis — INTERVAL BETWEEN ONSET AND DEATH: 2 - 7 days

181.6

DUE TO (b) Advanced Carcinoma of Bladder — 2 yrs, 9 mos.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES [X] NO [ ]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work [ ] Not While at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Feb. 2, 1962 to March 23, 1962 that (I) (we) last saw the deceased alive on March 23, 1962 and that death occured at 10:45 AM, from the causes and on the date stated above.

22a. SIGNATURE: Yosef H. Pilch, M.D.
22b. DATE SIGNED: March 23, 1962
ATTENDING PHYS. [ ] MED. DIRECTOR [ ] STAFF PHYS [X]
22c. PHYSICIAN'S NAME (Type): Yosef H. Pilch, M.D.
22d. ADDRESS: The Clinical Center, National Institutes of Health, Bethesda 14, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 3-25-62
23c. NAME OF CEMETERY OR CREMATORY: Evergreen
23d. LOCATION (City, town or county) (State): Luray Virginia

24. FUNERAL DIRECTOR'S SIGNATURE: DM Eichenberger
ADDRESS: Vienna Virginia
25a. REC'D BY REGISTRAR DATE MAR 27 '62
25b. REGISTRAR'S SIGNATURE

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

**MARYLAND STATE DEPARTMENT OF HEALTH**

**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

03356

# CERTIFICATE OF DEATH

03349

1. **PLACE OF DEATH** a. COUNTY: Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: 8 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Washington San Hospital

MARYLAND

2. **USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
d. STREET ADDRESS: 8600 Glenview Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Arthur Middle: Tillman Last: Britt
4. **DATE OF DEATH** Month: 3 Day: 24 Year: 1962
5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 1-10-20
9. AGE (In years last birthday): 42 yrs. IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Main Tenance - Library of Cong
10b. KIND OF BUSINESS OR INDUSTRY: U.S. Government
11. BIRTHPLACE (County & State, or foreign country): Georgia
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: William F. Britt
14. MOTHER'S MAIDEN NAME: Eva M. Sullivan
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service)
16. SOCIAL SECURITY NO.
17. **INFORMANT** Address: Hospital Record.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Hepatic Coma — INTERVAL BETWEEN ONSET AND DEATH: 1 week.
DUE TO (b) Advanced Cirrhosis of Liver — 6 years.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Bronchopneumonia Severe Hypoalbuminemia Hypoprothrombinemia
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) ~~(this hospital)~~ attended the deceased from Aug 13, 1956 to March 24, 1962 that (I) ~~(was)~~ last saw the deceased alive on March 23, 1962 and that death occured at 3:50 A.M. from the causes and on the date stated above.

22a. SIGNATURE: Russell B. Arnold M.D.
22b. DATE SIGNED: 3/24/62
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22c. PHYSICIAN'S NAME (Type): Russell B. Arnold M.D.
22d. ADDRESS: 8801 Colesville Road, Silver Spring, Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: March 27-1962
23c. NAME OF CEMETERY OR CREMATORY: George Washington Cemetery
23d. LOCATION (City, town or county): Adelphi. (State): Md

24. FUNERAL DIRECTOR'S SIGNATURE: Arthur Walters. ADDRESS: 254 Carroll St. N.W. Takoma Park DC
25a. REC'D BY REGISTRAR DATE: MAR 28 62
25b. REGISTRAR'S SIGNATURE: Arthur L. Thomas

**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03357 **CERTIFICATE OF DEATH** 03350

**1. PLACE OF DEATH**
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: 2 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Washington Sanitarium + Hospital

**2. USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
d. STREET ADDRESS: 604 Bonifant Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

**3. NAME OF DECEASED** (Type or print): First: Bernice — Middle: Clara — Last: Broome

**4. DATE OF DEATH**: Month: Mar — Day: 20 — Year: 1962

**5. SEX**: Female

**6. COLOR OR RACE**: White

**7. MARRIED** ☐ **NEVER MARRIED** ☐ **WIDOWED** ☑ **DIVORCED** ☐

**8. DATE OF BIRTH**: 3-20-01

**9. AGE** (In years last birthday): 60 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): HW

**10b. KIND OF BUSINESS OR INDUSTRY**:

**11. BIRTHPLACE** (County & State, or foreign country): Indiana

**12. CITIZEN OF WHAT COUNTRY?**: USA.

**13. FATHER'S NAME**: McClain

**14. MOTHER'S MAIDEN NAME**: Not Available

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unkown): NO
(If yes give war or dates of service):

**16. SOCIAL SECURITY NO.**:

**17. INFORMANT**: Hospital Records — Address:

MEDICAL CERTIFICATION

**18. CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 3/18/62.
DUE TO (b) 260X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) Diabetes Mellitus — 10 yrs.

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

**19. WAS AUTOPSY PERFORMED?** YES ☑ NO ☐

**20a. ACCIDENT WAS UNDERLYING** ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER):

**20b. DESCRIBE HOW INJURY OCCURED.** (Enter nature of injury in Part I or Part II of item 18.)

**20c. TIME OF INJURY** Hour a.m. p.m. Month, Day, Year 19

**20d. INJURY OCCURRED** While at work ☐ Not While at work ☐

**20e. PLACE OF INJURY** (Home, farm, factory, street, office bldg., etc.)

**20f.** (City or town) (County) (State)

21 **I certify** that (I) (this hospital) attended the deceased from 1/11/1952 to 3/20/1962 that (I) (we) last saw the deceased alive on 3/20/1962, and that death occured at 3:05 M, from the causes and on the date stated above.

**22a. SIGNATURE**: Howard T. Morse — M.D.
ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐

**22b. DATE SIGNED**: 3/20/62

**22c. PHYSICIAN'S NAME** (Type): Howard T. Morse

**22d. ADDRESS**: 7030 Carroll Ave Takoma Park Md

**23a. BURIAL, CREMATION, REMOVAL** (Specify): Burial

**23b. DATE THEREOF**: March 23, 1962

**23c. NAME OF CEMETERY OR CREMATORY**: Arlington National Cemetery

**23d. LOCATION** (City, town or county): Arlington, (State): Virginia

**24. FUNERAL DIRECTOR'S SIGNATURE**: J. Arthur Walters — ADDRESS: 254 Carroll St. N.W. Wash. D.C.

**25a. REC'D BY REGISTRAR** DATE MAR 22 '62

**25b. REGISTRAR'S SIGNATURE**: Arthur S. Kruse

**TO HOSP L OR ATTENDING PHYSICIAN:** The law requires that the death certificate be execu . thin 24 hours a. death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician

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# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03358

## CERTIFICATE OF DEATH

03351

1. PLACE OF DEATH
a. COUNTY: Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 1 day
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Suburban Hospital

MARYLAND

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rockville, maryland.
d. STREET ADDRESS: 705 marshall Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Lyda Middle: Mae Last: Broome
4. DATE OF DEATH: Month: mar Day: 22 Year: 1962

5. SEX: Female
6. COLOR OR RACE: W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Jan 3, 1919
9. AGE (In years last birthday): 43 yrs.
IF UNDER 1 YEAR: Months | Days
IF UNDER 24 HRS.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (County & State or foreign country): Columbia S. Carolina
12. CITIZEN OF WHAT COUNTRY? USA.

13. FATHER'S NAME: William P. Swygert
14. MOTHER'S MAIDEN NAME: LYDA Roberts

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): NO
16. SOCIAL SECURITY NO.: 578-14-9440
17. INFORMANT: milton Broome, Address: 705 marshall Ave Rockville md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): toxemia, hemorrhage
TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b): adrenal cortical failure
DUE TO
(c): stress ulcer (gastric), intestinal fistulas

INTERVAL BETWEEN ONSET AND DEATH: 2 wks; 6 yrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): previous advanced cancer uterus, fistulas

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 1-5-52, 19__, to 3-22, 1962 that (I) (we) last saw the deceased alive on 3-21, 1962 and that death occured at 11:35 AM, from the causes and on the date stated above.

22a. SIGNATURE: John O Robben M.D.
ATTENDING PHYS. ☒ MED DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 3/23/62
22c. PHYSICIAN'S NAME (Type): JOHN O. ROBBEN
22d. ADDRESS: 1015 Spring St Silver Spring Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 3/26/62
23c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Cemetery
23d. LOCATION (City, town or county): Suitland, (State): Maryland

24. FUNERAL DIRECTOR'S SIGNATURE: Raymond A. Zeke
ADDRESS: WARNER E. PUMPHREY INC. 8434 GEORGIA AVE., SILVER SPRING, MD.
25a. REC'D BY REGISTRAR: DATE MAR 27 '62
25b. REGISTRAR'S SIGNATURE: Arthur L. Frank

director, page 3 should be detached for use as the burial/cremation permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03359 **CERTIFICATE OF DEATH** 03352

1. PLACE OF DEATH
a. COUNTY: Montgomery
MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda (Rural)
c. LENGTH OF STAY IN 1b: 2 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): U. S. Naval Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
d. STREET ADDRESS: 4302 Ferrara Drive
e. IS RESIDENCE ON A FARM? YES [ ] NO [X]

3. NAME OF DECEASED (Type or print): First: Donald Middle: Kenneth Last: Brown
4. DATE OF DEATH: Month: March Day: 24, Year: 19 62
5. SEX: Male
6. COLOR OR RACE: Caucasian
7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: January 18, 1922
9. AGE (In years last birthday): 40 yrs. IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hours: Min.:
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Naval Officer
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Washington
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Harry Jesse Brown
14. MOTHER'S MAIDEN NAME: Edna Viola Wearth
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): Yes WW II
16. SOCIAL SECURITY NO.: 538 26 9705
17. INFORMANT: WIFE: Address: Mrs. Edna P. Brown, Same as #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a) (b) and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocardial infarction
DUE TO (b) Coronary insufficiency
DUE TO (c) Arteriosclerosis

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

INTERVAL BETWEEN ONSET AND DEATH: 25 hrs.

PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES [X] NO [ ]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work [ ] Not While at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (X) (this hospital) attended the deceased from March 23, 1962 to March 24, 1962 that (X) (we) last saw the deceased alive on March 24, 1962, and that death occured at 11:32 AM from the causes and on the date stated above

22a. SIGNATURE: Joseph H. Eusterman M.D.
22b. DATE SIGNED: March 24, 1962
ATTENDING PHYS. [ ] MED DIRECTOR [ ] STAFF PHYS. [X]
22c. PHYSICIAN'S NAME (Type): JOSEPH H. EUSTERMAN LT MC USN
22d. ADDRESS: U. S. Naval Hospital, Bethesda, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 3-30-62
23c. NAME OF CEMETERY OR CREMATORY: Ivy Lawn Cemetery
23d. LOCATION (City, town or county) (State): Oxnard, California

24. FUNERAL DIRECTOR'S SIGNATURE: W. W. Chambers Funeral Home, 1400 Chapin St. NW
ADDRESS: Wash., D.C.
25a. REC'D BY REGISTRAR DATE: MAR 28 '62
25b. REGISTRAR'S SIGNATURE: Clifford S. Hanna

W W Chambers

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
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# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

03360 03353

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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1. PLACE OF DEATH
a. COUNTY: Montgomery County
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park Md
MARYLAND LENGTH OF STAY IN 1b: 11 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Washington Sam. & Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 2. Silver Spring
d. STREET ADDRESS: 609 Univ. Blvd. W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Philip Middle: Peter Last: Brown
4. DATE OF DEATH: Month: March Day: 18 Year: 19 62
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 1-29-83
9. AGE (In years last birthday): 79 yrs. IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Plate Printer
10b. KIND OF BUSINESS OR INDUSTRY: U.S. GOVERNMENT
11. BIRTHPLACE (County & State, or foreign country): Ohio
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Robert J. Brown
14. MOTHER'S MAIDEN NAME: Isabel F Rice
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service): None
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Washington Sam. & Hosp. Takoma Park Md. Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Hypostatic pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 1 day
DUE TO (b): Cerebral Vascular Occlusion — 5 days
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Nephrectomy (Unspecified) 3-8-62
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Mar. 17, 1962 to Mar. 18, 1962 that (I) (we) last saw the deceased alive on Mar. 18 1962 and that death occured at 5:25 P.M. from the causes and on the date stated above.

22a. SIGNATURE: John P. Haberlin M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 3/18/62
22c. PHYSICIAN'S NAME (Type): John P. Haberlin
22d. ADDRESS: 1115 Spring St Silver Spring

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 3-21-62
23c. NAME OF CEMETERY OR CREMATORY: Fort Lincoln Cemetery
23d. LOCATION (City, town or county) (State): Prince George's Co. Maryland

24. FUNERAL DIRECTOR'S SIGNATURE: Raymond A. Zieber ADDRESS: 8434 Georgia Ave
Warner E. Pumphrey, Inc. Silver Spring, Maryland
25a. REC'D BY REGISTRAR DATE MAR 20 '62
25b. REGISTRAR'S SIGNATURE: Ethel S. Nuss

VR A15 (4)
15M 7/61

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# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03361

## CERTIFICATE OF DEATH

03354

**1. PLACE OF DEATH**
a. COUNTY: Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 44 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): The Clinical Center, Bethesda 14, Md.

**2. USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring,
d. STREET ADDRESS: 8714 Leonard Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

**3. NAME OF DECEASED** (Type or print): First: Ethel; Middle: (No middle name); Last: Burgess

**4. DATE OF DEATH**: Month: March; Day: 6; Year: 19 62

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 1 November 1890
9. AGE (In years last birthday): 71 yrs. IF UNDER 1 YEAR: Months, Days; IF UNDER 24 HRS.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Practical Nurse & Office Nursing
10b. KIND OF BUSINESS OR INDUSTRY: worker
11. BIRTHPLACE (County & State, or foreign country): Washington, D.C.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: William Sedgwick
14. MOTHER'S MAIDEN NAME: Sarah Hall Decker
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No (If yes give year or dates of service): —
16. SOCIAL SECURITY NO.: None
17. INFORMANT: The Medical Record, (Address) The Clinical Center, Bethesda 14, Maryland

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Necrotizing pneumonia left lower lobe and lingula, right lower lobe — INTERVAL BETWEEN ONSET AND DEATH: 6 days
DUE TO
(b) Viral hepatitis with early post hepatitic cirrhosis — 2 months
DUE TO
(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Status post operative total pelvic exenteration for Epidermoid Carcinoma of the uterine cervix.

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from January 21 1962 to March 6, 1962, that (I) (we) last saw the deceased alive on March 6 1962, and that death occured at 9:55 AM, from the causes and on the date stated above

22a. SIGNATURE: Yosef H. Pilch, M.D. M.D.
ATTENDING PHYS. ☐ MED DIRECTOR ☐ STAFF PHYS ☒
22b. DATE SIGNED: March 6, 1962
22c. PHYSICIAN'S NAME (Type): Yosef H. Pilch, M.D.
22d. ADDRESS: The Clinical Center, National Institutes of Health, Bethesda 14, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 3-9-62
23c. NAME OF CEMETERY OR CREMATORY: FT. LINCOLN CEMETERY
23d. LOCATION (City, town or county) (State): PRINCE GEORGE COUNTY, MD.

24. FUNERAL DIRECTOR'S SIGNATURE: H. Don. DeVol
ADDRESS: 2224 - Wis Ave NW
25a. REC'D BY REGISTRAR: DATE MAR 9 '62
25b. REGISTRAR'S SIGNATURE: Lindsay S. Keene

**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VII A15 (4)
15M 9/60

Item 16 Film 310 4-5

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03362

# CERTIFICATE OF DEATH

03355

**1. PLACE OF DEATH**
a. COUNTY: Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN HOSPITAL: 231 Days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): The Clinical Center, Bethesda 14, Md.

MARYLAND

**2. USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
a. STATE: Pennsylvania
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Harrisburg,
d. STREET ADDRESS: 1720 North 3rd Street,
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

**3. NAME OF DECEASED** (Type or print): First: Jane; Middle: Charlotte; Last: Burley

**4. DATE OF DEATH**: Month: March; Day: 22; Year: 1962

**5. SEX**: Female

**6. COLOR OR RACE**: White

**7. MARRIED** ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

**8. DATE OF BIRTH**: 14 July 1921

**9. AGE** (In years last birthday): 40 yrs.

IF UNDER 1 YEAR: Months: ; Days: ; IF UNDER 24 HRS.: Hours: ; Min.:

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): Housewife

**10b. KIND OF BUSINESS OR INDUSTRY**: None

**11. BIRTHPLACE** (County & State, or foreign country): Pennsylvania

**12. CITIZEN OF WHAT COUNTRY?**: U.S.A.

**13. FATHER'S NAME**: Paul Timothy

**14. MOTHER'S MAIDEN NAME**: Catherine Rice

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unknown): No (If yes give war or dates of service): Not available

**16. SOCIAL SECURITY NO.**:

**17. INFORMANT**: The Medical Record, Address: The Clinical Center, Bethesda 14, Maryland

**18. CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arterial Hypertension
152.7
DUE TO (b) Malignant Carcinoid (primary tumor of the distal ileum)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c)

INTERVAL BETWEEN ONSET AND DEATH: 48 Hours

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Pneumothorax, left

**19. WAS AUTOPSY PERFORMED?** YES ☒ NO ☐

**20a. ACCIDENT WAS UNDERLYING** ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

**20b. DESCRIBE HOW INJURY OCCURRED.** (Enter nature of injury in Part I or Part II of item 18.)

**20c. TIME OF INJURY** Hour a.m. p.m. Month, Day, Year 19

**20d. INJURY OCCURRED** While at work ☐ Not While at work ☐

**20e. PLACE OF INJURY** (Home, farm, factory, street, office bldg., etc.)

**20f.** (City or town) (County) (State)

**21. I certify** that (I) (this hospital) attended the deceased from August 3, 1961, to March 22, 1962, that (I) (we) last saw the deceased alive on March 22, 1962, and that death occured at 11:30 AM from the causes and on the date stated above.

**22a. SIGNATURE**: Michael Field

**22b. DATE SIGNED**: 3-23-62

**22c. PHYSICIAN'S NAME** (Type): Michael Field M.D.

M.D. ATTENDING PHYS. ☐ MED DIRECTOR ☐ STAFF PHYS. ☒

**22d. ADDRESS**: The Clinical Center, National Institutes of Health, Bethesda 14, Md.

**23a. BURIAL, CREMATION, REMOVAL** (Specify): Burial

**23b. DATE THEREOF**: 3/26/62

**23c. NAME OF CEMETERY OR CREMATORY**: East Harrisburg Cem.

**23d. LOCATION** (City, town or county): Harrisburg, Penna. (State)

**24 FUNERAL DIRECTOR'S SIGNATURE**: Robert A. Pumphrey, Bethesda, Maryland

ADDRESS:

**25a. REC'D BY REGISTRAR** DATE: MAR 27 '62

**25b. REGISTRAR'S SIGNATURE**

MEDICAL CERTIFICATION

**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

03363 03356

**1. PLACE OF DEATH**
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN this place: 4 days 23 hrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Suburban

**2. USUAL RESIDENCE** (Where deceased lived. If institution: Residence before admission)
a. STATE: Md.
b. COUNTY: Mont. Co.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
d. STREET ADDRESS: 1206 - Noyes Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

**3. NAME OF DECEASED** (Type or print): First: Jewel Middle: Le Maria Last: Burns

**4. DATE OF DEATH**: Month: 3 Day: 12 Year: 1962

**5. SEX**: Female

**6. COLOR OR RACE**: White

**7. MARRIED** ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

**8. DATE OF BIRTH**: 7/10/99

**9. AGE** (In years last birthday): 62 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): Beautician

**10b. KIND OF BUSINESS OR INDUSTRY**: Beauty Culture

**11. BIRTHPLACE** (County & State, or foreign country): New York

**12. CITIZEN OF WHAT COUNTRY?**: U.S.A.

**13. FATHER'S NAME**: Martin Le Maria

**14. MOTHER'S MAIDEN NAME**: Josephine De Pasquale

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unknown): No

**16. SOCIAL SECURITY NO.** (If yes give war or dates of service): 577-36-0123H

**17. INFORMANT**: Edward A. Burns — Address: 1206 Noyes Dr. Silver Spring, Md.

**18. CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinoma of Breast c Metastasis — INTERVAL BETWEEN ONSET AND DEATH: 6 years
DUE TO (b) Acute Heart Failure — 6 mos.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

**19. WAS AUTOPSY PERFORMED?** YES ☐ NO ☒

**20a. ACCIDENT WAS UNDERLYING** ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

**20b. DESCRIBE HOW INJURY OCCURRED.** (Enter nature of injury in Part I or Part II of item 18.)

**20c. TIME OF INJURY** Hour a.m. p.m. Month, Day, Year 19

**20d. INJURY OCCURRED** While at work ☐ Not While at work ☐

**20e. PLACE OF INJURY** (Home, farm, factory, street, office bldg., etc.)

**20f.** (City or town, (County) (State)

**21. I certify** that (I) (this hospital) attended the deceased from 6/1 1955 to 3/12 1962, that (I) (we) last saw the deceased alive on 3/12 1962, and that death occured at 4:20 PM, from the causes and on the date stated above.

**22a. SIGNATURE**: John E. Everett M.D. — ATTENDING PHYS. ☒ MED DIRECTOR ☐ STAFF PHYS ☐

**22b. DATE SIGNED**: 3/12/62

**22c. PHYSICIAN'S NAME** (Type): JOHN E. EVERETT

**22d. ADDRESS**: 9400 Conn Ave Kensington Md

**23a. BURIAL, CREMATION, REMOVAL** (Specify): Burial

**23b. DATE THEREOF**: 3-16-62

**23c. NAME OF CEMETERY OR CREMATORY**: Gate of Heaven Cemetery

**23d. LOCATION** (City, town or county) (State): Silver Spring Montgomery Co. Md.

**24 FUNERAL DIRECTOR'S SIGNATURE**: Raymond A. Zeller — ADDRESS: 8434 Georgia Ave.
Warner E. Pumphrey, Inc., Silver Spring, Maryland

**25a. REC'D BY REGISTRAR** DATE: MAR 15 '62

**25b. REGISTRAR'S SIGNATURE**: William S. Kruse

MEDICAL CERTIFICATION

**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/60

FOR STATE HEALTH DEPT.

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any, as necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03364 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 03357

1. PLACE OF DEATH
a. COUNTY: Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rockville (rural)
c. LENGTH OF STAY IN 1b: 5 yrs
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Old Balto. Rd

MARYLAND

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Md
b. COUNTY: Montg
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rockville - 13 Cy
d. STREET ADDRESS: Old Balto. Rd
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEDENT (Type or print): First: Maggie; Middle: Stanton; Last: Butler

4. DATE OF DEATH: Month: Mar; Day: 16; Year: 1962

5. SEX: Female
6. COLOR OR RACE: Col
7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]
8. DATE OF BIRTH: 8-5-1868
9. AGE (In years last birthday): 93 yrs.
IF UNDER 1 YEAR: Months | Days
IF UNDER 24 HRS.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Md
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Harry Stanton
14. MOTHER'S MAIDEN NAME: Elizabeth Snowden

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give were or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Della Welsh — Address: Ellicott City

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary occlusion
DUE TO (b) hypertension
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: unknown / yrs. / mos.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. EXTERNAL CAUSE WAS PRIMARY [ ] or CONTRIBUTING [ ] CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work [ ] Not While at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy [ ], Inspection [X], Inquiry [X], and in my opinion death resulted from: Natural causes [X], Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE: Frank J. Broschart MD
EXAMINER'S NAME (Type): FRANK J. BROSCHART
CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]
Address (Street, city, town, or county):
DATE SIGNED: 3-16-62

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 3/20/62
22c. NAME OF CEMETERY OR CREMATORY: Friendship Methodist
22d. LOCATION (City, town, or county) (State): Damacus, Md.

23. FUNERAL DIRECTOR: Robert L. Snowden
ADDRESS: Rockville, Md.
24a. REC'D BY REGISTRAR: DATE MAR 22 '62
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03365 Item 2 Film G509

## CERTIFICATE OF DEATH

Item 14 Film G508 3/14/62 iwk 3/16/62 iwk 03358

**1. PLACE OF DEATH**
a. COUNTY: Montgomery
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN this place: 3 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Washington Sanitarium and Hospital

**2. USUAL RESIDENCE** (Where deceased lived, if institutional Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Silver Springs
d. STREET ADDRESS: 35 Morrison St. N.W. Washington, D.C.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

**3. NAME OF DECEASED** (Type or print): First Norman Middle Franklin Last Butler

**4. DATE OF DEATH**: Month March Day 3 Year 1962

**5. SEX**: Male
**6. COLOR OR RACE**: White
**7. MARRIED** ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐
**8. DATE OF BIRTH**: May 5
**9. AGE** (In years last birthday): 80 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): Retired
**10b. KIND OF BUSINESS OR INDUSTRY**: Photographer
**11. BIRTHPLACE** (County & State, or foreign country): Massachusetts
**12. CITIZEN OF WHAT COUNTRY?**: U.S.A.

**13. FATHER'S NAME**: Franklin Butler
**14. MOTHER'S MAIDEN NAME**: Augusta E. Buck

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unknown): None
(If yes give war or dates of service)
**16. SOCIAL SECURITY NO**
**17. INFORMANT**: Washington Sanitarium and Hospital Address: Rockville

**18. CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Gangrenous Cholecystitis
~~DUE TO~~ (b): CIRRHOSIS OF LIVER
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): aneurysm of abdominal aorta

**19. WAS AUTOPSY PERFORMED?** YES ☒ NO ☐

**20a. ACCIDENT WAS UNDERLYING** ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)
**20b. DESCRIBE HOW INJURY OCCURED.** (Enter nature of injury in Part I or Part II of item 18.)
**20c. TIME OF INJURY** Hour a.m. p.m. Month, Day, Year 19
**20d. INJURY OCCURRED** While at work ☐ Not While at work ☐
**20e. PLACE OF INJURY** (Home, farm, factory, street, office bldg., etc.)
**20f.** (City or town) (County) (State)

**21. I certify** that (I) (this hospital) attended the deceased from ~~Mar~~ Feb 25, 1962 to Mar 3, 1962 that (I) (we) last saw the deceased alive on Mar 2, 1962 and that death occured at 2:35 A.M. from the causes and on the date stated above.

**22a. SIGNATURE**: Leonard L. Deitz M.D.
**22b. DATE SIGNED**: 4/5/62
ATTENDING PHYS. ☒ MED DIRECTOR ☐ STAFF PHYS. ☐
**22c. PHYSICIAN'S NAME** (Type): LEONARD L. DEITZ
**22d. ADDRESS**: 800 PERSHING DR SILVER SPRING MD

**23a. BURIAL, CREMATION, REMOVAL** (Specify): Cremation
**23b. DATE THEREOF**: 3/5/62
**23c. NAME OF CEMETERY OR CREMATORY**: Mt Lincoln
**23d. LOCATION** (City, town or county) (State): Md.

**24. FUNERAL DIRECTOR'S SIGNATURE** & ADDRESS: Glick & Reeter 1103 Wisconsin Ave N.W. Wash. D.C.

**25a. REC'D BY REGISTRAR** DATE MAR 8 '62
**25b. REGISTRAR'S SIGNATURE**: Clifton E. Frame

MEDICAL CERTIFICATION

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed in 24 hours after death. Page 4 should be retained by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

03366

## CERTIFICATE OF DEATH

03359

**1. PLACE OF DEATH**
a. COUNTY: Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 22 min
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Suburban Hospital

**2. USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rockville
d. STREET ADDRESS: 219 Highland Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

**3. NAME OF DECEASED** (Type or print): First: BABY Middle: BOY Last: BUTT

**DATE OF DEATH**: Month: March Day: 20 Year: 1962

5. SEX: MALE
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 3/19/62
9. AGE (In years last birthday) yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min. 22

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): —
10b. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (County & State, or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: HARRY PRESTON BUTT
14. MOTHER'S MAIDEN NAME: BERNICE GEORGIA BURKE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): —
(If yes give war or dates of service): —
16. SOCIAL SECURITY NO: —
17. INFORMANT: MOTHER
Address: (SAME AS ABOVE)

**MEDICAL CERTIFICATION**

**18. CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Anoxia
761.5
DUE TO (b): Immaturity
DUE TO (c): Premature Separation of Placenta.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I.(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 3/19, 1962, to 3/20, 1962, that (I) (we) last saw the deceased alive on 3/19 1962, and that death occured at 12:02 A.M., from the causes and on the date stated above.

22a. SIGNATURE: James S. Stanton M.D.
22b. DATE SIGNED
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22c. PHYSICIAN'S NAME (Type): JAMES S STANTON
22d. ADDRESS: 809 View Hill Rd Rockville Md

23a. BURIAL, CREMATION, REMOVAL (Specify): CREMATION
23b. DATE THEREOF: 3-21-62
23c. NAME OF CEMETERY OR CREMATORY: SUBURBAN HOSPITAL
23d. LOCATION (City, town or county) (State): BETHESDA, MD.

24. FUNERAL DIRECTOR'S SIGNATURE: Amelia C. Carter, Admin. (per JB)
ADDRESS: Suburban Hospital Bethesda, Md.
25a. REC'D BY REGISTRAR: DATE MAR 22 '62
25b. REGISTRAR'S SIGNATURE: William S. Krauss

**TO HOSPITAL ATTENDING PHYSICIAN**: The law requires that the death certificate be executed within 24 hours after death. Page 4 is retained by the hospital or attending physician.
**TO FUNERAL DIRECTOR**: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

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# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

03367 — 03360

**1. PLACE OF DEATH**
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN (b): 1 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Washington Sanitarium

**2. USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
a. STATE: Wash. D.C.
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington
d. STREET ADDRESS: 1809 Owens Rd
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First: Frances — Middle: C. — Last: Carroll

4. DATE OF DEATH: Month: March — Day: 9 — Year: 1962

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☑ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 11-28-1882
9. AGE (In years last birthday): 79 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10b. KIND OF BUSINESS OR INDUSTRY: School Teacher
11. BIRTHPLACE (County & State, or foreign country): D.C.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: ~~Thomas~~ Wm. Carroll
14. MOTHER'S MAIDEN NAME: Mary Alice ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Clarence Carroll — Address: 1809 Owens Rd Oxon Hill Md

**MEDICAL CERTIFICATION**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a): Diabetic Acidosis — INTERVAL BETWEEN ONSET AND DEATH: 24 hrs.
DUE TO (b): Diabetes Mellitus — 7 years
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Arteriosclerosis, Senile
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from March 8, 1962 to March 9, 1962 that (I) (we) last saw the deceased alive on March 8, 1962 and that death occured at 2:30 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Philip E. Jones, M.D.
22b. DATE SIGNED: 3/9/62
22c. PHYSICIAN'S NAME (Type): Philip E. Jones
ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐
22d. ADDRESS: 718 Ellsworth Drive B.L. Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Mar. 12-62
23c. NAME OF CEMETERY OR CREMATORY: Cedar Hill
23d. LOCATION (City, town or county): Suitland (State): Md

24. FUNERAL DIRECTOR'S SIGNATURE: Simmons Bro.
ADDRESS: 1661 Good Hope Rd S.E. Wash 20 DC
25a. REC'D BY REGISTRAR: DATE MAR 12 '62
25b. REGISTRAR'S SIGNATURE: C. Dan Kuna

**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 is retained by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03368 **CERTIFICATE OF DEATH** 03361

1. PLACE OF DEATH
a. COUNTY: Montgomery, MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Kensingston,
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Carroll Hall Sant.

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Mass.
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Malden
d. STREET ADDRESS: 50 x 3
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First EVA Middle M Last CARTER

4. DATE OF DEATH: Month MARCH Day 19 Year 1962

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: August 7, 1874
9. AGE (In years last birthday): 87 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Nova Scotia
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Sylvias Mosher
14. MOTHER'S MAIDEN NAME: Eunice Dinsmore

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) No (If yes give year or dates of service)
16. SOCIAL SECURITY NO. 015-26-5480
17. INFORMANT: E.N. Read
Address: 6905 Maple Ave. Chev. Ch., Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARCINOMA OF MOUTH
DUE TO (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): SENILITY

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Nov. 29, 1969 to March 19, 1962 that (I) (we) last saw the deceased alive on March 19 1962 and that death occured at 4:45 PM, from the causes and on the date stated above.

22a. SIGNATURE: Wenzer Sowden M.D.
22b. DATE SIGNED: 3/19/62
22c. PHYSICIAN'S NAME (Type):
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22d. ADDRESS: 5206 Norway Dr Chevy Chase, Md

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 3/21/62
23c. NAME OF CEMETERY OR CREMATORY: Puritan Lawn Mem. Pk.
23d. LOCATION (City, town or county): West Peobody, Mass. (State)

24. FUNERAL DIRECTOR'S SIGNATURE: Fil W. Kerr
ADDRESS: Wash. D.C.
25a. REC'D BY REGISTRAR DATE MAR 22 '62
25b. REGISTRAR'S SIGNATURE: Clifton S. Kraus

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

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# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03369 **CERTIFICATE OF DEATH** 03362

**1. PLACE OF DEATH**
a. COUNTY: MONTGOMERY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): TAKOMA PARK, MD
c. LENGTH OF STAY IN 1b: D.O.A.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): WASHINGTON SANITARIUM & HOSP.

**2. USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: PRINCE GEORGES
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HYATTSVILLE,
d. STREET ADDRESS: 5906 - 14TH. PLACE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

**3. NAME OF DECEASED** (Type or print): First JOHN Middle L. Last CASHELL

**4. DATE OF DEATH**: Month March Day 27 Year 1962

**5. SEX**: male

**6. COLOR OR RACE**: white

**7. MARRIED** ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

**8. DATE OF BIRTH**: Sept 1, 1910

**9. AGE** (In years last birthday): 51 yrs. | IF UNDER 1 YEAR: Months, Days | IF UNDER 24 HRS.: Hours, Min.

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): ACCOUNTANT

**10b. KIND OF BUSINESS OR INDUSTRY**: U.S. GOV'T.

**11. BIRTHPLACE** (County & State, or foreign country): WASHINGTON, D.C.

**12. CITIZEN OF WHAT COUNTRY?**: U.S.A.

**13. FATHER'S NAME**: HARRY M. CASHELL

**14. MOTHER'S MAIDEN NAME**: FANNIE L. LAVELL

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unknown): No (If yes give war or dates of service)

**16. SOCIAL SECURITY NO.**: 577-22-3062

**17. INFORMANT**: Mrs. Irene M. Cashell Address: Same as #2

**18. CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Insufficiency — INTERVAL BETWEEN ONSET AND DEATH

DUE TO (b) Coronary Atherosclerosis

DUE TO (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 420.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Previous Myocardial Infarction

**19. WAS AUTOPSY PERFORMED?** YES ☐ NO ☒

**20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

**20b. DESCRIBE HOW INJURY OCCURED.** (Enter nature of injury in Part I or Part II of item 18.)

**20c. TIME OF INJURY** Hour a.m. p.m. Month, Day, Year 19

**20d. INJURY OCCURRED** While at work ☐ Not While at work ☐

**20e. PLACE OF INJURY** (Home, farm, factory, street, office bldg., etc.)

**20f.** (City or town) (County) (State)

MEDICAL CERTIFICATION

**21. I certify** that (I) (~~this hospital~~) attended the deceased from Feb 1956 to March 27, 1962, that (I) (~~we~~) last saw the deceased alive on March 27 1962 and that death occured at 7:25 PM, from the causes and on the date stated above.

**22a. SIGNATURE**: Richard L. Whelton M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

**22b. DATE SIGNED**: March 27, 1962

**22c. PHYSICIAN'S NAME** (Type): RICHARD L. WHELTON

**22d. ADDRESS**: 1021 University Blvd E Silver Spring Md

**23a. BURIAL, CREMATION, REMOVAL** (Specify): Burial

**23b. DATE THEREOF**: 3-31-62

**23c. NAME OF CEMETERY OR CREMATORY**: Mt Olivet Cemetery

**23d. LOCATION** (City, town or county) (State): Washington, D.C.

**24. FUNERAL DIRECTOR'S SIGNATURE**: Francis J. Collins

ADDRESS: 3821-14th St. N.W. Wash. D.C.

**25a. REC'D BY REGISTRAR** DATE APR 2 '62

**25b. REGISTRAR'S SIGNATURE**: William E. Kruse

**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed and filed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

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# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

03370 — 03363

**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 4 should be retained by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VII A15 (4)
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1. PLACE OF DEATH
a. COUNTY: Montgomery
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 54 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): The Clinical Center, Bethesda 14, Md.

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Ohio
b. COUNTY: MARYLAND
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Waverly
d. STREET ADDRESS: Route # 3, Box 377
e. IS RESIDENCE ON A FARM? YES [ ] NO [X]

3. NAME OF DECEASED (Type or print): First: Anna — Middle: Jane — Last: Cassady
4. DATE OF DEATH: Month: March — Day: 12 — Year: 19 62
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: January 2, 1924
9. AGE (In years last birthday): 38 yrs. IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Baby Sitter
10b. KIND OF BUSINESS OR INDUSTRY: Domestic
11. BIRTHPLACE (County & State, or foreign country): Kentucky
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Rush Cassady
14. MOTHER'S MAIDEN NAME: Elma Bond
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: Unascertainable
17. INFORMANT: The Medical Record — Address: The Clinical Center, Bethesda 14, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac arrest
DUE TO (b) Congestive heart failure following operation: teflon graft anastomosis between left subclavian artery and left pulmonary artery
DUE TO (c) Corrected tranposition of great vessels with left-sided Ebstein's phenomenon and tetralogy of fallot and atrial septal defect

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: 17 days

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
(c)(Cont.)

19. WAS AUTOPSY PERFORMED? YES [X] NO [ ]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work [ ] Not While at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (X) (this hospital) attended the deceased from January 17, 1962, to March 12, 1962, that (I) (we) last saw the deceased alive on March 12, 1962, and that death occured at 5:20PM from the causes and on the date stated above.

22a. SIGNATURE: W B Berry, M.D.
22b. DATE SIGNED: 3/13/62
ATTENDING PHYS. [ ] MED. DIRECTOR [ ] STAFF PHYS. [X]
22c. PHYSICIAN'S NAME (Type): W. B. Berry, M.D.
22d. ADDRESS: The Clinical Center, National Institutes of Health, Bethesda 14, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 3/15/62
23c. NAME OF CEMETERY OR CREMATORY: Cassady Cemetery
23d. LOCATION (City, town or county) (State): Inez, Kentucky

24. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Robert A. Pumphrey, Bethesda, Maryland

25a. REC'D BY REGISTRAR — DATE: MAR 15 '62
25b. REGISTRAR'S SIGNATURE: Arthur S. Hanson

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FOR STATE HEALTH DEPT.

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**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any [illegible] is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03371 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 03364

1. PLACE OF DEATH
a. COUNTY: Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN Md: MARYLAND D.O.A.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Wash Sant Hosp

2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
d. STREET ADDRESS: 2109 Dexter St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Henri Middle Louis Last Chamberland

4. DATE OF DEATH: Month 3 Day 6 Year 1962

5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 2-23-10
9. AGE (In years last birthday): 52 yrs. IF UNDER 1 YEAR: Months, Days; IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Accountant
10b. KIND OF BUSINESS OR INDUSTRY: Navy Dept
11. BIRTHPLACE (State or foreign country): Mass.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Alex Chamberland
14. MOTHER'S MAIDEN NAME: Josephine Ouellette

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): Yes (If yes, give war or dates of service): 2nd WW
16. SOCIAL SECURITY NO.: 579-40-9687
17. INFORMANT: Ann Chamberland Address: Same as Deceased

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: Sudden
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
420.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II. of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I **certify** that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ and in my opinion death resulted from. Natural causes ☒. Accident ☐. Suicide ☐. Homicide ☐. Undetermined manner ☐

ACTUAL SIGNATURE: Frank J. Broschart M.D.
EXAMINER'S NAME (Type): FRANK J. BROSCHART
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town or county):
DATE SIGNED: 3-7-62

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 3-10-62
22c. NAME OF CEMETERY OR CREMATORY: Gate of Heaven Cemetery
22d. LOCATION (City, town or county): Montgomery County (State): Maryland

23. FUNERAL DIRECTOR: Francis J. Collin
ADDRESS: 3821-14th St. N.W. Wash, D.C.

24a. REC'D BY REGISTRAR DATE: MAR 9 62
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

# MARYLAND STATE DEPARTMENT OF HEALTH

**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

03372 **CERTIFICATE OF DEATH** 03365

**1. PLACE OF DEATH**
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
c. LENGTH OF STAY IN 1b: 30 years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 9306 Flower Avenue

**2. USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 22 Silver Spring
d. STREET ADDRESS: 9306 Flower Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

**3. NAME OF DECEASED** (Type or print): First: Edith — Middle: C — Last: Childs

**4. DATE OF DEATH**: Month: March — Day: 9 — Year: 19 62

**5. SEX**: Female

**6. COLOR OR RACE**: White

**7. MARRIED** ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

**8. DATE OF BIRTH**: Oct. 24, 1897

**9. AGE** (In years last birthday): 64 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): Housewife

**10b. KIND OF BUSINESS OR INDUSTRY**: own home

**11. BIRTHPLACE** (County & State or foreign country): Louisiana

**12. CITIZEN OF WHAT COUNTRY?**: U.S.A.

**13. FATHER'S NAME**: Edward Cole

**14. MOTHER'S MAIDEN NAME**: Elizabeth Frances Eastman

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unknown): No — (If yes give war or dates of service): None

**16. SOCIAL SECURITY NO.**: None

**17. INFORMANT**: Leroy M. Childs — Address: 9306 Flower Ave, Silver Spring Md.

**MEDICAL CERTIFICATION**

**18. CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cor Pulmonale — INTERVAL BETWEEN ONSET AND DEATH
DUE TO (b): Pulmonary Emphysema — 8 years
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

**19. WAS AUTOPSY PERFORMED?** YES ☐ NO ☒

**20a. ACCIDENT WAS UNDERLYING** ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

**20b. DESCRIBE HOW INJURY OCCURRED.** (Enter nature of injury in Part I or Part II of item 18.)

**20c. TIME OF INJURY** Hour a.m. p.m. Month, Day, Year 19

**20d. INJURY OCCURRED** While at work ☐ Not While at work ☐

**20e. PLACE OF INJURY** (Home, farm, factory, street, office bldg., etc.)

**20f.** (City or town) (County) (State)

**21. I certify** that (I) (~~this hospital~~) attended the deceased from 1951, 1951 to March 9, 1962 that (I) (~~we~~) last saw the deceased alive on March 5 19 62, and that death occured at 1 A.M. from the causes and on the date stated above

**22a. SIGNATURE**: John W. Trenis — M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

**22b. DATE SIGNED**: 3-9-62

**22c. PHYSICIAN'S NAME** (Type): John W. Trenis

**22d. ADDRESS**: 1150 Connecticutt Ave, N.W., Washington, D.C.

**23a. BURIAL, CREMATION, REMOVAL** (Specify): Burial

**23b. DATE THEREOF**: 3-12-62

**23c. NAME OF CEMETERY OR CREMATORY**: St. John's Cemetery

**23d. LOCATION** (City, town or county) (State): Olney Montgomery Maryland

**24 FUNERAL DIRECTOR'S SIGNATURE**: Raymond A. Zeke — ADDRESS: 8434 Georgia Ave

Warner E. Pumphrey, Inc. Silver Spring, Maryland

**25a. REC'D BY REGISTRAR** DATE: AUG 13 '62

**25b. REGISTRAR'S SIGNATURE**: Arthur L. Kraus

**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Please retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03373

## CERTIFICATE OF DEATH

Reg. Dist. No. 03366

**1. PLACE OF DEATH** a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chevy Chase Village
c. LENGTH OF STAY IN 1b: 50 years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: R1 West Irving Street

**2. USUAL RESIDENCE** (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chevy Chase Village, Sec. II
d. STREET ADDRESS: R1 West Irving Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

**3. NAME OF DECEASED** (Type or print): First: Mary — Middle: Swingle — Last: Clark

**4. DATE OF DEATH**: Month: March — Day: 30 — Year: 1962

**5. SEX**: Female
**6. COLOR OR RACE**: White
**7. MARRIED** ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐
**8. DATE OF BIRTH**: December 4, 1876
**9. AGE** (In years last birthday): 85 yrs.
IF UNDER 1 YEAR: Months — Days; IF UNDER 24 HRS.: Hours — Min

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): House wife
**10b. KIND OF BUSINESS OR INDUSTRY**: None
**11. BIRTHPLACE** (State or foreign country): Washington, D.C.
**12 CITIZEN OF WHAT COUNTRY?**: U.S.A.

**13. FATHER'S NAME**: Robert Duncan Swingle
**14. MOTHER'S MAIDEN NAME**: Emma Catherine Johnston

**15. WAS DECEASED EVER IN U. S. ARMED FORCES?** (Yes, no, or unknown): No — (If yes, give war or dates of service): None
**16. SOCIAL SECURITY NO.**: None
**INFORMANT**: Charles C. Clark Jr, 403 Perry St, Fairfax, Va.

**MEDICAL CERTIFICATION**

**18. CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 6 days
DUE TO (b): Cerebral arteriosclerosis — 3+ yrs.
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

33 1X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

**19 WAS AUTOPSY PERFORMED?** YES ☐ NO ☒

**20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)**
**20b. DESCRIBE HOW INJURY OCCURRED.** (Enter nature of injury in Part I or Part II of item 18)
**20c. TIME OF INJURY** Month, Day, Year — Hour a.m. p.m. — 19
**20d. INJURY OCCURRED** While at work ☐ Not while at work ☐
**20e. PLACE OF INJURY** (Home, farm, factory, street, office bldg., etc.)
**20f.** (City or town) (County) (State)

**21. I certify** that I attended the deceased from 10 DEC 1960 to 30 Mar. 1962 that I last saw the deceased alive on 28 Mar 1962 and that death occurred at 9:05 p.m., from the causes and on the date stated above.

ACTUAL SIGNATURE: A.H. Richwine M.D. — ADDRESS (Street, city or town, state): 5522 Western Ave — DATE SIGNED: 31 MAR.
PHYSICIAN'S NAME (Type): A.H. RICHWINE, MD, Ch. Ch. 15, Md. 1962

**22a. BURIAL, CREMATION, REMOVAL** (Specify): Burial
**22b. DATE THEREOF**: 4/3/62
**22c. NAME OF CEMETERY OR CREMATORY**: Oak Hill
**22d. LOCATION** (City, town, or county) (State): Washington, D.C.

**23. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS**: Tyson Wheeler Funeral Home-1331 E. Montg. Ave. Rockville, Maryland
**24a. REC'D BY REGISTRAR** DATE: APR 3 '62
**24b. REGISTRAR'S SIGNATURE**: Arthur S. Kraus

**TO HOSPITAL OR ATTENDING PHYSICIAN**: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned to hospital or attending physician.
**TO FUNERAL DIRECTOR**: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/58

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03374

## CERTIFICATE OF DEATH

03367

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**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1. PLACE OF DEATH
a. COUNTY: Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chevy Chase
c. LENGTH OF STAY IN Md: MARYLAND
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 4517 Willard Avenue

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chevy Chase
d. STREET ADDRESS: 4517 Willard Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

56
1

3. NAME OF DECEASED (Type or print): First: Addie; Middle: ; Last: Constantine

4. DATE OF DEATH: Month: 3; Day: 11; Year: 1962

5. SEX: Female
6. COLOR OR RACE: White
7. MARITAL STATUS: MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 2/10/78
9. AGE (In years last birthday): 84 yrs. IF UNDER 1 YEAR: Months: ; Days: ; IF UNDER 24 HRS.: Hours: ; Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): U. S. Gov't, Ret
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Washington, DC
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William Martin
14. MOTHER'S MAIDEN NAME: Olivia Walker

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
(If yes give wars or dates of service):
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Fannie C. Scott-daughter-same 2d
Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CEREBRAL THROMBOSIS — INTERVAL BETWEEN ONSET AND DEATH: MINUTES
DUE TO (b): GENERALIZED ARTERIOSCLEROSIS — 10 YRS
DUE TO (c): ADVANCING YRS

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I.(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from JUNE, 1956 to MARCH, 1962, that (I) (we) last saw the deceased alive on 3/8, 1962, and that death occured at 4P M, from the causes and on the date stated above.

22a. SIGNATURE: [signature]
22b. DATE SIGNED: 3/13/62
22c. PHYSICIAN'S NAME (Type): LEON I DONOVAN M.D
M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22d. ADDRESS: 8218 WISCONSIN AVE BETHESDA MD

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 3/13/62
23c. NAME OF CEMETERY OR CREMATORY: Glenwood Cemetery
23d. LOCATION (City, town or county): Washington, D. C. (State)

24. FUNERAL DIRECTOR'S SIGNATURE: Robert A. Pumphrey, Bethesda, Maryland
ADDRESS:
25a. REC'D BY REGISTRAR: DATE MAR 15 '62
25b. REGISTRAR'S SIGNATURE: [signature]

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03375

## CERTIFICATE OF DEATH

03368

**1. PLACE OF DEATH**
a. COUNTY: MONTGOMERY
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): WHEATON
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): BEL PRE NURSING HOME

**2. USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
a. STATE: DISTRICT of Columbia
b. COUNTY: ✓
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): WASHINGTON D.C.
d. STREET ADDRESS: 2330 SKYLAND PL. S.E.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

**3. NAME OF DECEASED** (Type or print): First: IDA Middle: E Last: COOLEY.

**4. DATE OF DEATH**: Month: MARCH Day: 20 Year: 1962

**5. SEX**: FEMALE

**6. COLOR OR RACE**: white

**7. MARRIED** ☐ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☑

**8. DATE OF BIRTH**: AUGUST 11, 1896

**9. AGE** (In years last birthday): 65 yrs | IF UNDER 1 YEAR: Months: Days: | IF UNDER 24 HRS.: Hours: Min.:

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): Dept. Store.

**10b. KIND OF BUSINESS OR INDUSTRY**: SALESLADY

**11. BIRTHPLACE** (County & State, or foreign country): WASHINGTON, D.C.

**12. CITIZEN OF WHAT COUNTRY?**: U.S.

**13. FATHER'S NAME**: William Z. Howard

**14. MOTHER'S MAIDEN NAME**: MARY SMITH

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unknown): NO (If yes give war or dates of service):

**16. SOCIAL SECURITY NO.**:

**17. INFORMANT**: Address: MR. Richard Cooley, 11333 Schykill, Rockv.

**MEDICAL CERTIFICATION**

**18. CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Metastatic Cancer to Brain & Spinal Cord

DUE TO (b): Cancer, Primary Site Unknown Prob

DUE TO (c): Kidney or Pancreas

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: 8 Months / 1 year

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

**19. WAS AUTOPSY PERFORMED?** YES ☐ NO ☒

**20a. ACCIDENT WAS UNDERLYING** ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

**20b. DESCRIBE HOW INJURY OCCURED.** (Enter nature of injury in Part I or Part II of item 18.)

**20c. TIME OF INJURY** Hour a.m. p.m. Month, Day, Year 19

**20d. INJURY OCCURRED** While at work ☐ Not While at work ☐

**20e. PLACE OF INJURY** (Home, farm, factory, street, office bldg., etc.)

**20f.** (City or town) (County) (State)

**21. I certify** that (I) (this hospital) attended the deceased from 11/29, 1961, to 3/20, 1962, that (I) (we) last saw the deceased alive on 3/19, 1962, and that death occured at 7:50 A.M. from the causes and on the date stated above.

**22a. SIGNATURE** Max G. Sherer M.D.

**22b. DATE SIGNED**

ATTENDING PHYS. ☐ MED. DIRECTOR ☑ STAFF PHYS. ☐

**22c. PHYSICIAN'S NAME** (Type): MAX G. SHERER, MD

**22d. ADDRESS**: 2025 EAST West H'way Silver Spring Md

**23a. BURIAL, CREMATION, REMOVAL** (Specify): Burial

**23b. DATE THEREOF**: Mar. 23-62

**23c. NAME OF CEMETERY OR CREMATORY**: Cedar Hill Cemetery

**23d. LOCATION** (City, town or county) (State): Suitland Md

**24. FUNERAL DIRECTOR'S SIGNATURE**: Simmons Bros Funeral Home

ADDRESS: 1661-Good Hope Rd SE WASH 20 DC

**25a. REC'D BY REGISTRAR** DATE MAR 21 '62

**25b. REGISTRAR'S SIGNATURE**: Arthur S. Kraus

**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR ATS (4)
ISM 7,61

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# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03376 — It m-4 Film G309 — 3/19/62 · iwk — 03369

## CERTIFICATE OF DEATH

1. PLACE OF DEATH
a. COUNTY: Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rockville.
c. LENGTH OF STAY: MARYLAND
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): 214 Frederick Ave.,

2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 09 Rockville.,
d. STREET ADDRESS: 214 Frederick Ave.,
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First MILOY Middle C. Last COOPER
4. DATE OF DEATH: Month March Day 5, Year 19 62
5. SEX: female
6. COLOR OR RACE: colored
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Nov. 5, 1905
9. AGE (In years last birthday): 56 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME: Henson Carroll
14. MOTHER'S MAIDEN NAME: Florence Hayes
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wars or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Nelson Cooper Address: Item # 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial failure — INTERVAL BETWEEN ONSET AND DEATH: 1 month
443X
DUE TO (b) Arteriosclerotic hypertensive cardiovascular disease — 10 years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO (c) Left hemiplegia in 1957

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a): none
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 1957, 19, to March 5, 1962, that (I) (we) last saw the deceased alive on March 5 1962, and that death occured at 10:30 P.M. from the causes and on the date stated above

22a. SIGNATURE: Wm A. Lothiemus M.D.
ATTENDING PHYS. ☒ MED DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 3/6/62
22c. PHYSICIAN'S NAME (Type): Wm A Lothiemus
22d. ADDRESS: 110 S. Washington St. Rockville Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 3-9-62
23c. NAME OF CEMETERY OR CREMATORY: St. Marys,
23d. LOCATION (City, town or county) (State): Rockville, Md

24. FUNERAL DIRECTOR'S SIGNATURE: Robert L. Sunter
ADDRESS: Rockville, Md
25a. REC'D BY REGISTRAR DATE MAR 14 '62
25b. REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1

FOR STATE HEALTH DEPT.

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03377

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03370

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bellsville
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Hunter Rd

2. USUAL RESIDENCE (Where deceased lived, if institutional residence before admission)
a. STATE: Maryland
b. COUNTY: Montg.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bellsville (rural)
d. STREET ADDRESS: Hunter Rd.
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First Pernell — Middle Cooper — Last
4. DATE OF DEATH: Month March — Day 11 — Year 1962

5. SEX: male
6. COLOR OR RACE: col.
7. MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: 2/3/62
9. AGE (In years last birthday) yrs. — IF UNDER 1 YEAR: Months 1, Days 8 — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Lewis Cooper
14. MOTHER'S MAIDEN NAME: Edith Harper

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Police Report — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Asphyxia
DUE TO (b) Upper Respiratory Infection
DUE TO (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: Found dead in bed

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. EXTERNAL CAUSE WAS PRIMARY [ ] or CONTRIBUTING [ ] CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work [ ] Not While at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy [ ], Inspection [X], Inquiry [X], and in my opinion death resulted from: Natural causes [X], Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE: Frank J. Broschart M.D.
EXAMINER'S NAME (Type): Frank J. Broschart
CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]
Address (Street, city, town, or county)
DATE SIGNED: Mar. 11, 1962

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 3/14/62
22c. NAME OF CEMETERY OR CREMATORY: Elijah Church Cemetery
22d. LOCATION (City, town, or country): Poolesville, Md. (State)

23. FUNERAL DIRECTOR: Robert L. Snowden — ADDRESS: Rockville, Md.
24a. REC'D BY REGISTRAR DATE: MAR 15 '62
24b. REGISTRAR'S SIGNATURE: Irvin L. Kimes

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any [illegible] is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

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2-C2x031

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03378 03371

**1. PLACE OF DEATH** a. COUNTY: Montgomery County MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda

c. LENGTH OF STAY IN Hospital: DOA

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Suburban Hospital

**2. USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission) a. STATE: D.C. b. COUNTY:

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington

d. STREET ADDRESS: 3154 Tennyson Street, N.W.

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

**3. NAME OF DECEASED** (Type or print): First: Gail Middle: Walden Last: Crossen

**4. DATE OF DEATH** Month: 3/26/62 Day: Year: 19

**5. SEX:** Male

**6. COLOR OR RACE:** White

**7. MARRIED** ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

**8. DATE OF BIRTH:** 2/26/93

**9. AGE** (In years last birthday): 69 yrs. IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hours: Min.:

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): banker retired

**10b. KIND OF BUSINESS OR INDUSTRY:**

**11. BIRTHPLACE** (State or foreign country): Ohio

**12. CITIZEN OF WHAT COUNTRY?** U.S.A.

**13. FATHER'S NAME:** Daniel I. Crossen

**14. MOTHER'S MAIDEN NAME:** ~~Helen~~ Theresa Horn

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unknown): No (If yes give wars or dates of service)

**16. SOCIAL SECURITY NO.:** Unknown

**17. INFORMANT:** Helen A. Crossen (wife) Address: Same

**MEDICAL CERTIFICATION**

**18. CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion

DUE TO (b)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

INTERVAL BETWEEN ONSET AND DEATH: sudden

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

**19. WAS AUTOPSY PERFORMED?** YES ☐ NO ☒

**20a.** EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

**20b.** DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

**20c.** TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

**20d.** INJURY OCCURRED While at work ☐ Not While at work ☐

**20e.** PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

**20f.** (City or town) (County) (State)

**21.** I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Frank J. Broschart M.D.

EXAMINER'S NAME (Type): FRANK J. Broschart

CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒

Address (Street, city, town, or county):

DATE SIGNED: 3-26-62

**22a.** BURIAL, CREMATION, REMOVAL (Specify): Burial

**22b.** DATE THEREOF: 3/29/62

**22c.** NAME OF CEMETERY OR CREMATORY: Rock Creek Cemetery

**22d.** LOCATION (City, town, or country): Washington, D. C. (State)

**23.** FUNERAL DIRECTOR: Robert A. Humphrey ADDRESS: Bethesda, Maryland

**24a.** REC'D BY REGISTRAR DATE: MAR 30 '62

**24b.** REGISTRAR'S SIGNATURE: Walter S. Krause

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any ... is necessary please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9,60

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

03379 03372

1 M I

**1. PLACE OF DEATH**
a. COUNTY: ~~Maryland~~ Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: MARYLAND
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Suburban

**2. USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Mont.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Kensington
d. STREET ADDRESS: 4300 Glenrose St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Helen ~~Marie~~ Middle: Marie Last: Crossette
4. DATE OF DEATH: Month: March Day: 15, Year: 1962
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: May 22, 1888
9. AGE (In years last birthday): 73 yrs. IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10b. KIND OF BUSINESS OR INDUSTRY: Housewife
11. BIRTHPLACE (County & State, or foreign country): ~~W.~~ Iowa
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Charles Pearce
14. MOTHER'S MAIDEN NAME: Clara White
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
16. SOCIAL SECURITY NO.: Unknown
17. INFORMANT: George Crossette-Son-same 2d Address:

**MEDICAL CERTIFICATION**

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Myocardial Infarction, Antero-septal — INTERVAL BETWEEN ONSET AND DEATH: 6 days
DUE TO (b): Coronary sclerosis
Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I, or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 3/9, 1962 to 3/15, 1962 that (I) (we) last saw the deceased alive on 3/14, 1962, and that death occured at 1:30 a.M. from the causes and on the date stated above.

22a. SIGNATURE: Stewart Clapp MD M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 3/15/62
22c. PHYSICIAN'S NAME (Type): Stewart Clapp MD
22d. ADDRESS: 4740 Chevy Chase Dr Chevy Chase Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 3/19/62
23c. NAME OF CEMETERY OR CREMATORY: Arlington Nat. Cem.
23d. LOCATION (City, town or county) (State): Arlington, Virginia

24 FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Robert A. Pumphrey, Bethesda, Maryland

25a. REC'D BY REGISTRAR DATE MAR 16 '62
25b. REGISTRAR'S SIGNATURE: [illegible]

**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1

FOR STATE HEALTH DEPT.

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03380

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03373

Items 13 & 14 [illegible]

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Germantown (rural)
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Violet Lock Rd.

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montg.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Germantown (rural)
d. STREET ADDRESS: Violet Lock Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Paul — Middle: A. — Last: Czichos

4. DATE OF DEATH: Month: Mar. — Day: 9, — Year: 1962

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒

8. DATE OF BIRTH: 6/15/97

9. AGE (In years last birthday): 64 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Gov. service (retired)

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Alvin Texas

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Frank Czichos

14. MOTHER'S MAIDEN NAME: Rosa [illegible]

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give wars or dates of service): Yes — War 1 & 2

16. SOCIAL SECURITY NO.: 402 [illegible]

17. INFORMANT: Police report — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a): Coronary occlusion

420.1

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH: sudden

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II, of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Frank J. Broschart M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED: Mar. 9, 1962

EXAMINER'S NAME (Type): Frank J. Broschart. Gaithersburg

Address (Street, city, town, or county)

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 3-14-62

22c. NAME OF CEMETERY OR CREMATORY: Arlington National

22d. LOCATION (City, town, or country): Arlington (State): Va.

23. FUNERAL DIRECTOR: Ernest C. Gartner. ADDRESS: Gaithersburg. Md.

24a. REC'D BY REGISTRAR: DATE MAR 15 '62

24b. REGISTRAR'S SIGNATURE: Clifford L. Hanes

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any [illegible] necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03381 Item 2 Film G308 3/12/62 iwk 03374

## CERTIFICATE OF DEATH

1. PLACE OF DEATH
a. COUNTY: Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 10 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Suburban Hospital

MARYLAND

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ~~Poolesville~~/ Silver Spring
d. STREET ADDRESS: 806 Wayne Avenue / ~~Matthews Home~~
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Robert Middle: D Last: Darby
4. DATE OF DEATH: Month: March Day: 1 Year: 1962
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Aug 4 1869
9. AGE (In years last birthday): 92 yrs. IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: THOMAS DARBY
14. MOTHER'S MAIDEN NAME: ELIZABETH DAWSON
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT (nephew) Address 806 Wayne Ave: Mr Gordon DARBY – Sil Sp.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bronchopneumonia
DUE TO (b): Myocarditis, Chronic
DUE TO (c): Senility

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: 2 wks

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I **certify** that (I) (this hospital) attended the deceased from June 9 1958 to Mar 1 1962, that (I) (we) last saw the deceased alive on Mar 1 1962 and that death occured at 2:30 A.M. from the causes and on the date stated above.

22a. SIGNATURE: Oliver E Thompson M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 3-1-62
22c. PHYSICIAN'S NAME (Type): Dr. Oliver Thompson
22d. ADDRESS: 901 Pershing Dr Silver Sp

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 3/3/62
23c. NAME OF CEMETERY OR CREMATORY: Meadowcacy
23d. LOCATION (City, town or county) (State): Beltsville, Md.

24. FUNERAL DIRECTOR'S SIGNATURE: William C. Hilton
ADDRESS: Barnesville, Md.
25a. REC'D BY REGISTRAR DATE MAR 6 '62
25b. REGISTRAR'S SIGNATURE: Arthur S Francis

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03382 **CERTIFICATE OF DEATH** 03375

Item 9 Film G311 4/13/62 mh

**1. PLACE OF DEATH** a. COUNTY ~~Prince George~~ Montgomery — MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park

c. LENGTH OF STAY IN 1b

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 7807 Garland Ave

**2. USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)

a. STATE: Md b. COUNTY: ~~Pr. George~~ Montgomery

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 19 Takoma Park

d. STREET ADDRESS: 7807 Garland Ave.

a. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF (Type or print): First: Annie Middle: M Last: Darne

4. DATE OF DEATH: Month: March Day: 18, Year: 1962

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: March 22, 1878

9. AGE (In years last birthday): 83 3/4 yrs. IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): At home

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Maryalnd

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Thomas W Webster

14. MOTHER'S MAIDEN NAME: Eliza Burrus

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): no (If yes give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Eppa W Darne — same as above. Address

**MEDICAL CERTIFICATION**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial failure — INTERVAL BETWEEN ONSET AND DEATH: 3 weeks

DUE TO (b) Coronary insufficiency — 4 yrs

DUE TO (c) Coronary atrio-sclerosis — 15 yr.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Feb. 28, 1962, to March 18, 1962, that (I) (we) last saw the deceased alive on 3/17, 1962, and that death occured at 8 A.M. from the causes and on the date stated above.

22a. SIGNATURE: Walter K Angevine M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): Walter K Angevine

22d. ADDRESS: 6300 - 13th St, NW, Wash. 11, D.C.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 3-20-62

23c. NAME OF CEMETERY OR CREMATORY: Congressional

23d. LOCATION (City, town or county): Washington D.C. (State)

24 FUNERAL DIRECTOR'S SIGNATURE: Lee Funeral Home — ADDRESS: Washington D.C.

25a. REC'D BY REGISTRAR DATE MAR 22 '62

25b. REGISTRAR'S SIGNATURE: Arthur L. Hiatt

**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

03383 **CERTIFICATE OF DEATH** 03376

**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda (Rural)
c. LENGTH OF STAY IN 16: 189 days,
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): U. S. Naval Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: D. C.
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington
d. STREET ADDRESS: 950 25th Street NW
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Mary — Middle: Jeanette — Last: Davis
4. DATE OF DEATH: Month: March — Day: 19 — Year: 62
5. SEX: Female
6. COLOR OR RACE: Caucasian
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: December 3, 1903
9. AGE (In years last birthday): 58 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: - - - - - -
11. BIRTHPLACE (County & State, or foreign country): Washington, D. C.
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Edward Sullivan
14. MOTHER'S MAIDEN NAME: Nettie C. Owens
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No — (If yes give were or dates of service): - - - - -
16. SOCIAL SECURITY NO.:
17. INFORMANT: Hospital Records — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Cancer of hypopharynx

DUE TO (b)

DUE TO (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

14 7X

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I (this hospital) attended the deceased from Sept. 11, 1961, to March 19, 19 62 that I (we) last saw the deceased alive on March 19, 19 62, and that death occured at 1:00 AM from the causes and on the date stated above.

22a. SIGNATURE: William C. Monell M.D.
22b. DATE SIGNED: March 19, 1962
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22c. PHYSICIAN'S NAME (Type): WILLIAM C. MONELL LT MC USN
22d. ADDRESS: U. S. Naval Hospital, Bethesda, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 22 March 1962
23c. NAME OF CEMETERY OR CREMATORY: Arlington National
23d. LOCATION (City, town or county) (State): Arlington, Virginia

24. FUNERAL DIRECTOR'S SIGNATURE: [illegible]
ADDRESS: DEVOL Funeral Home, 2224 Wisc. Ave., Wash., D. C.
25a. REC'D BY REGISTRAR: DATE MAR 22 '62
25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

VR AIS (4)
1SM 7'61

tem 18 Film 309 3-21

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

03384 — 03377

**1. PLACE OF DEATH**
a. COUNTY: Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 30 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): The Clinical Center, Bethesda 14, Md.

**2. USUAL RESIDENCE** (Where deceased lived, If Institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Kensington
d. STREET ADDRESS: 3112 McComas Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Argent; Middle: Elaine; Last: Denniston
4. DATE OF DEATH: Month: March; Day: 14; Year: 1962
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 25 November 1959
9. AGE (In years last birthday): 2 yrs. IF UNDER 1 YEAR: Months, Days; IF UNDER 24 HRS.: Hours, Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): child
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (County & State or foreign country): South Carolina
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Charles L. Denniston, Jr.
14. MOTHER'S MAIDEN NAME: Rosemary Brown
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service): None
16. SOCIAL SECURITY NO.: None
17. INFORMANT: The Medical Record, Address: The Clinical Center, Bethesda 14, Maryland

**MEDICAL CERTIFICATION**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSE BY: IMMEDIATE CAUSE (a) respiratory Acute Cardiorespiratory Failure — INTERVAL BETWEEN ONSET AND DEATH: 7 Months

204 - 3

DUE TO (b) Acute Myelocytic Leukemia

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Feb. 12, 1962 to March 14, 1962, that (I) (we) last saw the deceased alive on March 14, 1962, and that death occured at 1:45PM, from the causes and on the date stated above.

22a. SIGNATURE: Geo. H. Porter, III, M.D.
22b. DATE SIGNED: 3-14-62
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS ☒
22c. PHYSICIAN'S NAME (Type): George H. Porter M.D.
22d. ADDRESS: The Clinical Center, National Institutes of Health, Bethesda, 14, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 3/15/62
23c. NAME OF CEMETERY OR CREMATORY:
23d. LOCATION (City, town or county) (State): Columbia, D.C.

24. FUNERAL DIRECTOR'S SIGNATURE: W. W. Chambers Co.
ADDRESS: 1400 Rhode Island Ave. Washington D.C.
25a. REC'D BY REGISTRAR: DATE MAR 16 '62
25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03385

## CERTIFICATE OF DEATH

Reg. Dist. No. 03378

**1 PLACE OF DEATH**
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Kensington
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Carroll Hall Nursing Home

**2. USUAL RESIDENCE** (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 55 Chevy Chase
d. STREET ADDRESS: 5819 Highland Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

**3. NAME OF DECEASED** (Type or print): First J. Middle EDWARD Last DOMKE

**4. DATE OF DEATH**: Month MARCH Day 11 Year 1962

**5. SEX**: Male

**6. COLOR OR RACE**: White

**7. MARRIED** ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

**8. DATE OF BIRTH**: 4/4/68

**9. AGE** (In years last birthday): 93 yrs. — IF UNDER 1 YEAR: Months 11, Days 7 — IF UNDER 24 HRS: Hours, Min.

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): Salesman-retired

**10b. KIND OF BUSINESS OR INDUSTRY**: Selling

**11. BIRTHPLACE** (State or foreign country): Wisconsin

**12. CITIZEN OF WHAT COUNTRY?**: USA

**13. FATHER'S NAME**: Unknown

**14. MOTHER'S MAIDEN NAME**: Unknown

**15. WAS DECEASED EVER IN U. S. ARMED FORCES?** (Yes, no, or unknown): No — (If yes, give war or dates of service):

**16. SOCIAL SECURITY NO.**: 470-12-8447

**INFORMANT**: Adelaide W. Domke-wife-same above — Address:

**MEDICAL CERTIFICATION**

**18. CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARCINOMA OF INTESTINES
DUE TO
(b) CARCINOMA OF PROSTATE
DUE TO
(c) GENERALIZED ARTERIOSCLEROSIS

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): SENILITY

**19. WAS AUTOPSY PERFORMED?** YES ☐ NO ☒

**20a. ACCIDENT WAS UNDERLYING** ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

**20b. DESCRIBE HOW INJURY OCCURRED.** (Enter nature of injury in Part I or Part II of item 18.)

**20c. TIME OF INJURY** Month, Day, Year, Hour a. m. p. m. 19

**20d. INJURY OCCURRED** While at work ☐ Not while at work ☐

**20e. PLACE OF INJURY** (Home, farm, factory, street, office bldg., etc.)

**20f.** (City or town) (County) (State)

**21. I certify** that I attended the deceased from JAN. 15, 1962 to MARCH 11, 1962 that I last saw the deceased alive on MARCH 11, 1962 and that death occurred at 8:45 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Henry M. Lowden M.D. — ADDRESS (Street, city or town, state): 5206 Norway Dr. Chevy Chase, Md. — DATE SIGNED: 3/11/62

PHYSICIAN'S NAME (Type): Henry M. Lowden 5206 Norway Drive, Chevy Chase, Md.

**22a. BURIAL, CREMATION, REMOVAL** (Specify): Cremation 3/12/62

**22b. DATE THEREOF**

**22c. NAME OF CEMETERY OR CREMATORY**: Cedar Hill Crematory

**22d. LOCATION** (City, town, or county) (State): Suitland, Maryland

**23. FUNERAL DIRECTOR'S SIGNATURE** — ADDRESS: Robert A. Pumphrey, Bethesda, Maryland

**24a. REC'D BY REGISTRAR** DATE MAR 14 '62

**24b. REGISTRAR'S SIGNATURE**: [illegible]

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03386 **CERTIFICATE OF DEATH** 03379

Item 8 & esp, film Copy 3/22/62 jwk

**1. PLACE OF DEATH**
a. COUNTY: Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda (Rural)
c. LENGTH OF STAY IN 1b: 24 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): U. S. NAVAL HOSPITAL

**2. USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
a. STATE: District of Columbia
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington
d. STREET ADDRESS: 3500 Neward St., N.W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Benjamin; Middle: Henry; Last: Dorsey
4. DATE OF DEATH: Month: March; Day: 17; Year: 1962
5. SEX: Male
6. COLOR OR RACE: Caucasion
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: September 13, 1877 (1887)
9. AGE (In years last birthday): 84 yrs. IF UNDER 1 YEAR: Months / Days; IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Naval Officer
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Joshua W. Dorsey
14. MOTHER'S MAIDEN NAME: Elenor E. Watkins
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): Yes (If yes give wer or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT: Address:

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY: (Interval between onset and death)
IMMEDIATE CAUSE (a) Pneumonia, Lobar — 5 > d.s
DUE TO (b) Intestinal obstruction, Cause unknown
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Feb 21 1962 to Mar 17 1962, that (I) (we) last saw the deceased alive on 17 March 1962, and that death occured at 4:20 P.M. from the causes and on the date stated above.

22a. SIGNATURE: W. F. Warrender M.D.
22b. DATE SIGNED: 18 March 1962
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22c. PHYSICIAN'S NAME (Type): W.F. WARRENDER
22d. ADDRESS: U.S. NAVAL HOSPITAL, Bethesda, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: March 2[illegible]
23c. NAME OF CEMETERY OR CREMATORY: Arlington National
23d. LOCATION (City, town or county) (State): Arlington, Virginia
24. FUNERAL DIRECTOR'S SIGNATURE: Joseph Gawler's Sons by P. Smith
ADDRESS: N.W. Washington D.C.
JOSEPH GAWLER'S SONS INC. 1756 Pennsylvania Ave
25a. REC'D BY REGISTRAR DATE: MAR 20 '62
25b. REGISTRAR'S SIGNATURE: [illegible]

**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed in 24 hours after death. Page 1 should be retained by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7,61

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03387 **CERTIFICATE OF DEATH** 03380

1. PLACE OF DEATH
a. COUNTY: Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Kensington
c. LENGTH OF STAY IN 1b: MARYLAND
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 9916 Old Spring Road

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
e. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Kensington
d. STREET ADDRESS: 9916 Old Spring Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Madeline; Middle: G; Last: DRISCOLL

4. DATE OF DEATH: Month: March; Day: 5; Year: 1962

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Nov. 30, 1885

9. AGE (In years last birthday): 76 yrs. IF UNDER 1 YEAR: Months: 5; Days: 5 IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: -------

11. BIRTHPLACE (County & State, or foreign country): Illinois

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Peter P. Spiells

14. MOTHER'S MAIDEN NAME: (Unknown) Lyman

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Mrs. Henry Campbell-daughter-same 2d Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 5 MIN
DUE TO (b): Arteriosclerotic Heart Disease — Unknown
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 5/12, 1958 to 3/5, 1962, that (I) (we) last saw the deceased alive on March 1962 and that death occured at 4:19 P.M. from the causes and on the date stated above.

22a. SIGNATURE: George Sharpe M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 3/5/62

22c. PHYSICIAN'S NAME (Type): George Sharpe

22d. ADDRESS: 10511 Summit Ave., Kensington, Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial-Transit 3/8/62

23b. DATE THEREOF

23c. NAME OF CEMETERY OR CREMATORY: Morris Hill Cemetery

23d. LOCATION (City, town or county) (State): Boise, Idaho

24 FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Robert A. Pumphrey, Bethesda, Maryland

25a. REC'D BY REGISTRAR DATE MAR 9 '62

25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03388

# CERTIFICATE OF DEATH

Reg. Dist. No. 03381

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 17 Silver Spring
d. STREET ADDRESS: 1304 Dale Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: REGINA Middle: M. Last: DUGAN
4. DATE OF DEATH: Month: March Day: 12 Year: 1962
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: May 21, 1906
9. AGE (In years last birthday): 55 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Frank Graebenstein
14. MOTHER'S MAIDEN NAME: AnnaM. Drady
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO:
17. INFORMANT: Mr. John J. Dugan Address: 1304 Dale Drive, Silver Spring, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 3 weeks
DUE TO (b)
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
3 32 X
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Chronic renal insufficiency - one kidney removed - a gallstone [illegible]
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Sept. 4 1956, to 3/12, 1962, that I last saw the deceased alive on 3/12, 1962, and that death occurred at 11:10 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Edward J. Paccione M.D. ADDRESS (Street, city or town, state): 1746 K St. N.W. DATE SIGNED: 3/12/62
PHYSICIAN'S NAME (Type):

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 3/15/62
22c. NAME OF CEMETERY OR CREMATORY: Ft. Olivet Cemetery
22d. LOCATION (City, town, or county) (State): Washington, D.C.

23. FUNERAL DIRECTOR'S SIGNATURE: Chung Chow Funeral Home By Grant Bates ADDRESS: 5101 Georgia Ave. N.W. Wash. D.C.
24a. REC'D BY REGISTRAR DATE: MAR 15 '62
24b. REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be [illegible] the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled [illegible] the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03389 **CERTIFICATE OF DEATH** 03382

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 1 should be retained by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN MARYLAND: 9 Yrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 5721 Grosvenor Lane Resmor San & Hosp.

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Md. b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
d. STREET ADDRESS: 6203-Bannockburn Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First John; Middle Moyle; Last Duncan
4. DATE OF DEATH: Month March; Day 10; Year 19 62
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 9-25-1889
9. AGE (In years last birthday): 72 yrs. IF UNDER 1 YEAR: Months ___ Days ___ IF UNDER 24 HRS.: Hours ___ Min. ___
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Engineer
10b. KIND OF BUSINESS OR INDUSTRY: Gov,t
11. BIRTHPLACE (County & State, or foreign country): Toronto Canada
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: John T. Duncan
14. MOTHER'S MAIDEN NAME: Alice Lukes
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)
16. SOCIAL SECURITY NO: 227-07-3114
17. INFORMANT: Alice E. Duncan Address: Bethesda, Md. 4705-Bradley Blvd.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) General sepsis — INTERVAL BETWEEN ONSET AND DEATH: 1 mo.
DUE TO (b) Decubital ulcers — 5 mos.
DUE TO (c) Cerebral a generalized arteriosclerosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Hip fracture, rgt

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Month, Day, Year; Hour a.m. p.m. 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Sept., 1961, to Mar., 1962, that (I) (we) last saw the deceased alive on 3-9, 1962 and that death occured at 12:45 AM, from the causes and on the date stated above.

22a. SIGNATURE: Dorothy Gill, M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 3/10/62
22c. PHYSICIAN'S NAME (Type): Dorothy Gill, M.D.
22d. ADDRESS: 7511 Arlington Rd., Bethesda 14, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Cremation
23b. DATE THEREOF: 3/10/62
23c. NAME OF CEMETERY OR CREMATORY: Fort Lincoln Crematory
23d. LOCATION (City, town or county) (State): Prince Georges County, Md.

24. FUNERAL DIRECTOR'S SIGNATURE: The S.H.Kines Co. ADDRESS: 2901 14th Street, N.W. Washington 9, D.C.
25a. REC'D BY REGISTRAR DATE: MAR 12 '62
25b. REGISTRAR'S SIGNATURE: Arthur S. Kines

VR A15 (4) 15M 9/60

1

FOR STATE HEALTH DEPT.

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any [illegible] is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a Burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03390

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03383

1. PLACE OF DEATH
a. COUNTY: Mont
MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN Ib: 7 hrs. 30 min
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Suburban

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Md.
b. COUNTY: Mont.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chevy Chase
d. STREET ADDRESS: 4614 - Hunt Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Frank; Middle: C.; Last: Tunsmore

4. DATE OF DEATH: Month: March; Day: 1; Year: 1962

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 3/27/86
9. AGE (In years last birthday): 75 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Secretary (Col) Govt.
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Tennessee
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: James H. Connor
14. MOTHER'S MAIDEN NAME: Belle Powell

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service):
16. SOCIAL SECURITY NO.: —
17. INFORMANT: Arthur E. Tunsmore / Same — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial Infarction
DUE TO (b): Coronary Thrombosis
DUE TO (c): Coronary artery sclerosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: 8 hr.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I a: Fracture of skull

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☒ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.): Fall on concrete driveway at home
20c. TIME OF INJURY: Hour 2:00 p.m. Month, Day, Year: 3-1 1962
20d. INJURY OCCURRED: While at work ☐ Not While at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): home
20f. (City or town): Chevy Chase (County): Mont. (State): Md

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Frank J. Broschart M.D.
EXAMINER'S NAME (Type): FRANK J. Broschart
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county):
DATE SIGNED: Mar 2-1962

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 3/5/1962
22c. NAME OF CEMETERY OR CREMATORY: National Memorial Park
22d. LOCATION (City, town, or country): Falls Church, Virginia (State)

23. FUNERAL DIRECTOR: A. H. Hines Co.
ADDRESS: 2901 14th St. N.W.
24a. REC'D BY REGISTRAR: DATE MAR 5 '62
24b. REGISTRAR'S SIGNATURE: Arthur L. Hines

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FOR STATE HEALTH DEPT.

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03391

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03384

1. PLACE OF DEATH
a. COUNTY: Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
c. LENGTH OF STAY IN MARYLAND: 12 yrs
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 612 McNeill Rd

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Md
b. COUNTY: Monty
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
d. STREET ADDRESS: 612 McNeill Rd
e. IS RESIDENCE ON A FARM? YES [ ] NO [X]

3. NAME OF DECEASED (Type or print): First: Vincent; Middle: L.; Last: Eaton

4. DATE OF DEATH: Mar 16 1962 (Month, Day, Year)

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: 8-31-15
9. AGE (In years last b'rthday): 46 yrs. IF UNDER 1 YEAR: Months, Days; IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Publication Offic
10b. KIND OF BUSINESS OR INDUSTRY: Lib of Congress
11. BIRTHPLACE (State or foreign country): Venezuela
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Evan W. Eaton
14. MOTHER'S MAIDEN NAME: Inez Lanius

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): Yes (If yes give war or dates of service): WW II
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Dorothy Eaton (wife) Address: Highlands apts Conn. Ave - DC

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Barbiturate poisoning
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES [X] NO [ ]

20a. EXTERNAL CAUSE WAS PRIMARY [ ] or CONTRIBUTING [ ] CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work [ ] Not While at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy [X], Inspection [ ], Inquiry [ ], and in my opinion death resulted from: Natural causes [ ], Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [X]

ACTUAL SIGNATURE: Frank J. Broschart M.D.
EXAMINER'S NAME (Type): FRANK J. BROSCHART
CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]
Address (Street, city, town, or county):
DATE SIGNED: 3-17-62

22a. BURIAL, CREMATION, REMOVAL (Specify): Cremation
22b. DATE THEREOF: 3-17-62
22c. NAME OF CEMETERY OR CREMATORY: Fort Lincoln Crematory
22d. LOCATION (City, town, or country) (State): Prince George's Co. Maryland

23. FUNERAL DIRECTOR: Raymond A. Ziska ADDRESS: 8434 Georgia Ave.
Warner E. Pumphrey, Inc. Silver Spring, Maryland
24a. REC'D BY REGISTRAR: DATE MAR 20 '62
24b. REGISTRAR'S SIGNATURE: Arthur L. Thomas

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any ... is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

03392 — 03385

**1. PLACE OF DEATH**
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): 9514 Kentstone Drive

**2. USUAL RESIDENCE** (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and name of town): 45 Bethesda
d. STREET ADDRESS: 9514 Kentstone Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Mattie — Middle — Last Edwards
4. DATE OF DEATH: Month March — Day 23 — Year 19 62
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: July 31, 1887
9. AGE (In years last birthday): 74 yrs. — IF UNDER 1 YEAR: Months 7 Days 22 — IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife-US Govt
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State or foreign country): New Hampshire
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Fred C. Horner
14. MOTHER'S MAIDEN NAME: Barbara MacKenzie
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
(If yes give war or dates of service):
16. SOCIAL SECURITY NO.: None
17. INFORMANT: William Byrns-Cousin- Address: New Hampshire

**MEDICAL CERTIFICATION**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)

PART I DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) METASTATIC Ca. LUNG; PELVIS AND LIVER — INTERVAL BETWEEN ONSET AND DEATH

DUE TO (b)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) EPIDERMOID Ca. ABDOMINAL WALL. 2 years.

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I **certify** that (I) (this hospital) attended the deceased from FEB. 19 62 to MARCH 23, 19 62, that (I) (we) last saw the deceased alive on MARCH 19 19 62, and that death occured at 12:40 P.M. from the causes and on the date stated above.

22a. SIGNATURE: J. Blaine Fitzgerald M.D.
ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 3-23-62
22c. PHYSICIAN'S NAME (Type): J. Blaine Fitzgerald
22d. ADDRESS: 8218 Wisconsin Ave. Bethesda.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 3/26/62
23c. NAME OF CEMETERY OR CREMATORY: Wash. Nat. Cemetery
23d. LOCATION (City, town or county) (State): Washington, D. C.

24. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Robert A. Pumphrey, Bethesda, Maryland
25a. REC'D BY REGISTRAR DATE MAR 27 '62
25b. REGISTRAR'S SIGNATURE: Lucius S. Kraus

**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03393

## CERTIFICATE OF DEATH

03386

**1. PLACE OF DEATH**
a. COUNTY: Montgomery
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN MARYLAND: 10 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Suburban Hospital

**2. USUAL RESIDENCE** (Where deceased lived, if institution, residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): 44 Bethesda
d. STREET ADDRESS: 5329 Pooks Hill Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Alan; Middle: E.; Last: Evelyn

4. DATE OF DEATH: Month: March; Day: 3; Year: 1962

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 8/14/86
9. AGE (In years last birthday): 75 yrs. IF UNDER 1 YEAR: Months / Days; IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10b. KIND OF BUSINESS OR INDUSTRY: Telephone Co.
11. BIRTHPLACE (County & State, or foreign country): British West Indies
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Evelyn
14. MOTHER'S MAIDEN NAME: Mary New

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give years or dates of service): No.
16. SOCIAL SECURITY NO.: Yes-Unknown
17. INFORMANT: Same as above. Address: Rose Evelyn, Wife

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Thrombophlebitis of RT, Arm c EMBOLI TO BRAIN & LUNG — INTERVAL BETWEEN ONSET AND DEATH: 10 days
DUE TO (b): RADIATION FIBROSIS OF AXILLA + LYMPADEMA OF RT. ARM — 18 Months
DUE TO (c): LYMPHOSARCOMA — 6 years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from ....., 19 49 to MARCH 3, 1962, that (I) (we) last saw the deceased alive on MARCH 2, 1962, and that death occured at 8.45 AM, from the causes and on the date stated above.

22a. SIGNATURE: William Frank
22b. DATE SIGNED: 3/3/62
22c. PHYSICIAN'S NAME (Type): WILLIAM FRANK, M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22d. ADDRESS: 544 W. MONTGOMERY ROCKVILLE, MD

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 3/6/62
23c. NAME OF CEMETERY OR CREMATORY: Parklawn Cemetery
23d. LOCATION (City, town or county): Rockville, Maryland (State)

24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Robert A. Pumphrey, Bethesda, Maryland

25a. REC'D BY REGISTRAR DATE MAR 7 '62
25b. REGISTRAR'S SIGNATURE: Corinne S. Kraus

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

03394 03387

**1. PLACE OF DEATH**
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 19 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): The Clinical Center

**2. USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Suitland
d. STREET ADDRESS: 4738 Homer Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Mary; Middle: Agnes; Last: Ezzell
4. DATE OF DEATH: Month: March; Day: 24; Year: 1962
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: December 12, 1885
9. AGE (In years last birthday): 76 yrs. IF UNDER 1 YEAR: Months / Days; IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (County & State, or foreign country): New Jersey
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: William Flinn
14. MOTHER'S MAIDEN NAME: Rose Lee
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: Not available
17. INFORMANT: The Medical Record — Address: The Clinical Center, Bethesda 14, Maryland

**MEDICAL CERTIFICATION**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebrovascular accident
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: 7 days

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Mycosis fungoides

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I (this hospital) attended the deceased from March 5, 1962 to March 24, 1962 that I (we) last saw the deceased alive on March 24, 1962, and that death occured at 2:35 P.M., from the causes and on the date stated above

22a. SIGNATURE: Geo. H. Porter M.D.
22b. DATE SIGNED: March 24, 1962
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22c. PHYSICIAN'S NAME (Type): George H. Porter III, M.D.
22d. ADDRESS: The Clinical Center, National Institutes of Health, Bethesda 14, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: March 27-62
23c. NAME OF CEMETERY OR CREMATORY: Cedar Hill
23d. LOCATION (City, town or county) (State): Suitland, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE: Simmons Bros
ADDRESS: 1661 Pennsylvania Ave SE Washington DC
25a. REC'D BY REGISTRAR: DATE MAR 27 '62
25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8 Film 3310 4/5/62 mh

03395

## CERTIFICATE OF DEATH

Reg. Dist. No. 03388

**1. PLACE OF DEATH**
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): WHEATON
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: BEL PRE NURSING HOME

**2. USUAL RESIDENCE** (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: MONTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SILVER SPRING 31
d. STREET ADDRESS: 309 DENNIS AVE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

**3. NAME OF DECEASED** (Type or print): First: Bertha — Middle: — Last: Feldesman

**4. DATE OF DEATH**: Month: 3 — Day: 30 — Year: 1962

**5. SEX**: F

**6. COLOR OR RACE**: W

**7. MARRIED** ☐ **NEVER MARRIED** ☐ **WIDOWED** ☑ **DIVORCED** ☐

**8. DATE OF BIRTH**: APRIL 15, 1883

**9. AGE** (In years last birthday): 78 yrs.

IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS: Hours: — Min.: —

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): HW

**10b. KIND OF BUSINESS OR INDUSTRY**:

**11. BIRTHPLACE** (State or foreign country): ROUMANIA

**12. CITIZEN OF WHAT COUNTRY?**: U S A

**13. FATHER'S NAME**: JACOB SMILOWITZ

**14. MOTHER'S MAIDEN NAME**: RACHEL BERESOV

**15. WAS DECEASED EVER IN U. S. ARMED FORCES?** (Yes, no, or unknown): — (If yes, give war or dates of service):

**16. SOCIAL SECURITY NO.**:

**INFORMANT**: DR JACKSON FELDESMAN — Address: 309 DENNIS AVE SOM

**MEDICAL CERTIFICATION**

**18. CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 1 week
DUE TO (b) Cerebral Arteriosclerosis — 5 yrs
DUE TO (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

**19. WAS AUTOPSY PERFORMED?** YES ☐ NO ☑

**20a. ACCIDENT WAS UNDERLYING** ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER):

**20b. DESCRIBE HOW INJURY OCCURRED** (Enter nature of injury in Part I or Part II of item 18.):

**20c. TIME OF INJURY** Month, Day, Year — Hour a.m. p.m. — 19

**20d. INJURY OCCURRED** While at work ☐ Not while at work ☐

**20e. PLACE OF INJURY** (Home, farm, factory, street, office bldg., etc.):

**20f.** (City or town) (County) (State)

**21. I certify** that I attended the deceased from 1947, 19__, to 3/30, 1962. That I last saw the deceased alive on 3/29, 1962, and that death occurred at 4:30 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Irving W. Winik M.D. — ADDRESS (Street, city or town, state): 3900 McKinley St. NW — DATE SIGNED: 3/30/62

PHYSICIAN'S NAME (Type): Irving W. Winik — Washington 15, DC

**22a. BURIAL, CREMATION, REMOVAL** (Specify): APRIL 3, 1962

**22b. DATE THEREOF**:

**22c. NAME OF CEMETERY OR CREMATORY**: MT LEBANON CEMETERY

**22d. LOCATION** (City, town, or county) (State): QUEENS N.Y.

**23. FUNERAL DIRECTOR'S SIGNATURE**: B Kangsuetty & Son — ADDRESS: 3501-14 ST. NW.

**24a. REC'D BY REGISTRAR** DATE: APR 3 '62

**24b. REGISTRAR'S SIGNATURE**: Arthur L. Kraus

**TO HOSPITAL OR ATTENDING PHYSICIAN**: The law requires that the death certificate be executed within [redacted] after death. Page 4 may be obtained by the hospital or attending physician.

**TO FUNERAL DIRECTOR**: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/58

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03396 **CERTIFICATE OF DEATH** 03389

1. PLACE OF DEATH
a. COUNTY: Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
c. LENGTH OF STAY IN Md: MARYLAND
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 800 Midland Road

2. USUAL RESIDENCE (Where deceased lived, if institutional residence before admission)
a. STATE: Md
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
d. STREET ADDRESS: 800 Midland Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Susan Middle: Murphy Last: Ferguson

4. DATE OF DEATH: Month: Mar Day: 15 Year: 1962

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Oct. 23, 1902.

9. AGE (In years last birthday): 59 yrs. IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Homemaker

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (County & State, or foreign country): Goldsboro N.C.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: George Murphey

14. MOTHER'S MAIDEN NAME: Annie Patrick

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown)

16. SOCIAL SECURITY NO. (If yes give war or dates of service)

17. INFORMANT: Mrs. Robert G. Hires, Address: 800 Midland Rd. Sil Spg Md.

**MEDICAL CERTIFICATION**

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinoma of Rectum
DUE TO (b)
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: 2 years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 23 Dec 1961, to 15 Mar 1962, that (I) (we) last saw the deceased alive on 12 Mar 1962, and that death occured at 7 AM, from the causes and on the date stated above.

22a. SIGNATURE: H B Queen M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 15 Mar 1962

22c. PHYSICIAN'S NAME (Type): H. B. Queen

22d. ADDRESS: 7112 Willow Ave Takoma Park Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Mar 17, 1962

23c. NAME OF CEMETERY OR CREMATORY: Willowdale Cem.

23d. LOCATION (City, town or county): Goldsboro (State): N.Car.

24. FUNERAL DIRECTOR'S SIGNATURE: [illegible] ADDRESS: 254 Carroll St NW Wash 12 D.C.

25a. REC'D BY REGISTRAR DATE: MAR 16 '62

25b. REGISTRAR'S SIGNATURE: Carlton S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03397

## CERTIFICATE OF DEATH

03390

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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1. PLACE OF DEATH
a. COUNTY: Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN MARYLAND: 4½ hours
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Suburban Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Mont.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Bethesda
d. STREET ADDRESS: Route 3
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: Sally; Middle: M.; Last: Fitzell

4. DATE OF DEATH: Month: March; Day: 19; Year: 1962

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: 7/1/23
9. AGE (In years last birthday): 38 yrs. IF UNDER 1 YEAR: Months 8, Days 18; IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: -------
11. BIRTHPLACE (County & State or foreign country): Kentucky
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: William Stewart
14. MOTHER'S MAIDEN NAME: Mary Garrison
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No
16. SOCIAL SECURITY NO: ~~None~~
17. INFORMANT: Walter C. Fitzell, Address: Same As Above.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Respiratory failure — INTERVAL BETWEEN ONSET AND DEATH: 1 day
DUE TO (b) Pulmonary Metastases — 1 mos
DUE TO (c) Carcinoma of the Pancreas — 8 mos

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work [ ] Not While at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Jan. 19 63 to March 19 1962, that (I) (we) last saw the deceased alive on March 19 1962, and that death occured at 4:57 P.M. from the causes and on the date stated above.

22a. SIGNATURE: William Henry Killay, M.D.
ATTENDING PHYS. [✓] MED. DIRECTOR [ ] STAFF PHYS. [ ]
22b. DATE SIGNED: 3/19/62
22c. PHYSICIAN'S NAME (Type): William H. Killay
22d. ADDRESS: 8218 Wisconsin Ave Bethesda.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 3/22/62
23c. NAME OF CEMETERY OR CREMATORY: St. John Church Cem.
23d. LOCATION (City, town or county) (State): Kingsville, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: Robert A. Pumphrey, Bethesda, Maryland
25a. REC'D BY REGISTRAR: DATE MAR 22 '62
25b. REGISTRAR'S SIGNATURE: Carlton S. Keyes

VR A15 (4)
15M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

03398

## CERTIFICATE OF DEATH

03391

**1. PLACE OF DEATH**
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

**2. USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 21 Silver Spring
d. STREET ADDRESS: 816 Patton Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Esther — Middle: L — Last: Fleming

4. DATE OF DEATH: Month: March — Day: 1 — Year: 1962

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: March 23, 1894
9. AGE (In years last birthday): 67 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clerk
10b. KIND OF BUSINESS OR INDUSTRY: Retired-So. R. R.
11. BIRTHPLACE (County & State, or foreign country): New Hampshire
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William H. Wright
14. MOTHER'S MAIDEN NAME: Emma Davis

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give wer or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Florence F. Crawford — Address: 816 Patton Dr.

**MEDICAL CERTIFICATION**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinoma rectosigmoid with metastases
DUE TO (b): To liver, lungs & brain
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): None

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.): NONE
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from July 1959 to March 1 1962 that (I) (we) last saw the deceased alive on March 1 1962, and that death occured at 0550 P.M. from the causes and on the date stated above.

22a. SIGNATURE: James R. Goodson M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED:
22c. PHYSICIAN'S NAME (Type): James R Goodson
22d. ADDRESS: 1746 K ST N.W. Washington D.C.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 3-5-62
23c. NAME OF CEMETERY OR CREMATORY: Fort Lincoln Cemetery
23d. LOCATION (City, town or county): Bladensburg — (State): Maryland

24 FUNERAL DIRECTOR'S SIGNATURE: Deal Funeral Home — ADDRESS: 4812 Ga. Ave., N.W., Wash. DC
25a. REC'D BY REGISTRAR DATE MAR 8 '62
25b. REGISTRAR'S SIGNATURE: Clarence E. Krause

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03399

## CERTIFICATE OF DEATH

03392

1 PLACE OF DEATH
a. COUNTY: Montgomery
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN MARYLAND: 20 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): The Clinical Center, Bethesda 14, Md.

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Delaware
b. COUNTY:
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Wilmington
d. STREET ADDRESS: 118 Ruth Street
e. IS RESIDENCE ON A FARM? YES [ ] NO [X]

4 X 3

3. NAME OF DECEASED (Type or print): First: Evelyn; Middle: (None); Last: Ford

4. DATE OF DEATH: Month: March; Day: 2; Year: 1962

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: September 10, 1901
9. AGE (In years last birthday): 60 yrs. IF UNDER 1 YEAR: Months, Days; IF UNDER 24 HRS.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Cafeteria worker
10b. KIND OF BUSINESS OR INDUSTRY: Cafeteria
11. BIRTHPLACE (County & State, or foreign country): Delaware
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: James R. Lockerman
14. MOTHER'S MAIDEN NAME: Mary Hadley
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: 221-12-6401
17. INFORMANT: The Medical Record; Address: The Clinical Center, Bethesda 14, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Mycosis fungoides — INTERVAL BETWEEN ONSET AND DEATH: 8 years
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

20 SX

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work [ ] Not While at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from February 10, 1962, to March 2, 1962 that (I) (we) last saw the deceased alive on March 2, 1962, and that death occured at 3:00 AM from the causes and on the date stated above.

22a. SIGNATURE: Geo. H. Porter, III, M.D.
ATTENDING PHYS. [ ] MED. DIRECTOR [ ] STAFF PHYS. [X]
22b. DATE SIGNED: 3/2/62
22c. PHYSICIAN'S NAME (Type): George H. Porter, III, M.D.
22d. ADDRESS: The Clinical Center, National Institutes of Health, Bethesda 14, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 3-6-62
23c. NAME OF CEMETERY OR CREMATORY: Silver Brook
23d. LOCATION (City, town or county) (State): Wilmington Del.

24. FUNERAL DIRECTOR'S SIGNATURE: Neal Funeral Home
ADDRESS: 4812 Ga. Ave. Wash. D.C.
25a. RECEIVED BY REGISTRAR: DATE MAR 8 '62
25b. REGISTRAR'S SIGNATURE: Carolyn S. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03400 **CERTIFICATE OF DEATH** 03393

**1. PLACE OF DEATH**
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 1 day
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): The Clinical Center, Bethesda 14, Md.

**2. USUAL RESIDENCE** (Where deceased lived, if institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rockville
d. STREET ADDRESS: 1218 Rockville Pike
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

**3. NAME OF DECEASED** (Type or print): First: Forrest; Middle: (No middle Name); Last: Ford, Jr.

**4. DATE OF DEATH**: Month: March; Day: 29; Year: 19 62

**5. SEX**: Male

**6. COLOR OR RACE**: White

**7. MARRIED** ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

**8. DATE OF BIRTH**: 3 March 1899

**9. AGE** (In years last birthday): 63 yrs. — IF UNDER 1 YEAR: Months, Days; IF UNDER 24 HRS.: Hours, Min.

**10a. USUAL OCCUPATION** (Give kind of work during most of working life, even if retired): Industrial Equipment Operator

**10b. KIND OF BUSINESS OR INDUSTRY**: Fed. Government

**11. BIRTHPLACE** (County & State, or foreign country): Kentucky

**12. CITIZEN OF WHAT COUNTRY?**: U.S.A.

**13. FATHER'S NAME**: Forrest Ford, Sr.

**14. MOTHER'S MAIDEN NAME**: Dora Graham

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unknown): No — (If yes give war or dates of service)

**16. SOCIAL SECURITY NO.**: Not available

**17. INFORMANT**: The Medical Record — Address: The Clinical Center, Bethesda 14, Maryland

**MEDICAL CERTIFICATION**

**18. CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac arrest — INTERVAL BETWEEN ONSET AND DEATH: undetermined
DUE TO (b) Arteriosclerotic heart disease with coronary occlusion
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

420.0

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

**19. WAS AUTOPSY PERFORMED?** YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

**21. I certify** that (I) (this hospital) attended the deceased from March 29, 1962 to March 29, 1962, that (I) (we) last saw the deceased alive on March 29 1962, and that death occured at 8:15 A.M. from the causes and on the date stated above.

22a. SIGNATURE: David Horwitz M.D.

22b. DATE SIGNED: 3/29/62

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22c. PHYSICIAN'S NAME (Type): David Horwitz, M.D.

22d. ADDRESS: The Clinical Center, National Institutes of Health, Bethesda 14, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial-Transit 4/2/62

23b. DATE THEREOF

23c. NAME OF CEMETERY OR CREMATORY: Memorial Park

23d. LOCATION (City, town or county) (State): Dayton, Ohio

24 FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Robert A. Pumphrey, Bethesda, Maryland

25a. REC'D BY REGISTRAR — DATE: APR 2 '62

25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

**TO THE ATTENDING PHYSICIAN:** The law requires that the death certificate be executed in 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

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FOR STATE HEALTH DEPT.

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TO MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9.60

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03401 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 03394

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: 30 min
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Washington San & Hosp.

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): + Silver Springs
d. STREET ADDRESS: 824 Violet Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Floyd; Middle: Merl; Last: Foster
4. DATE OF DEATH: Month: 3; Day: 8; Year: 1962
5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 10-14-1884
9. AGE (In years last birthday): 77 yrs. IF UNDER 1 YEAR: Months / Days; IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Machinist
10b. KIND OF BUSINESS OR INDUSTRY: Naval Gun Factory
11. BIRTHPLACE (State or foreign country): Pennsylvania
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME: Foster
14. MOTHER'S MAIDEN NAME: Ammanda Tarr
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): no (If yes give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mrs. Elsie M. Foster, (same as #2) Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: 1/2 hr
420-1
DUE TO (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Frank J. Broschart M.D.
EXAMINER'S NAME (Type): FRANK J. BROSCHART
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county):
DATE SIGNED: Mar 8 1962

22a. BURIAL, CREMATION, REMOVAL (Specify): Entombment
22b. DATE THEREOF: March 12. 1962
22c. NAME OF CEMETERY OR CREMATORY: ~~Fort Lincoln Mausoleum~~ Lincoln Memorial Gardens
22d. LOCATION (City, town, or county): Prince Georges County (State): Maryland
23. FUNERAL DIRECTOR: Arthur Walters
ADDRESS: 254 Carroll St. N.W. Wash. D.C.
24a. REC'D BY REGISTRAR: DATE MAR 12 '62
24b. REGISTRAR'S SIGNATURE: [illegible]

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**TO HOSPITAL PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Form 4 may be retained by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR ATS (4)
1SM 7/61

# MARYLAND STATE DEPARTMENT OF HEALTH

**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

03402

## CERTIFICATE OF DEATH

03395

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda (rural)
c. LENGTH OF STAY IN 1b: 3 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): U.S. Naval Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Virginia
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Alexandria
d. STREET ADDRESS: 603 Ferry Landing Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Winfield — Middle: Stover — Last: FRANCIS

4. DATE OF DEATH: Month: March — Day: 17 — Year: 1962

5. SEX: Female
6. COLOR OR RACE: Cauc
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 12-22-33
9. AGE (In years last birthday): 28 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Pennsylvania
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Henry Watson Stover
14. MOTHER'S MAIDEN NAME: Dorothy Armstrong

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: HUS: Evans J. Francis — Address: Same As #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Sarcoma, unclassified
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from March 13, 1962 to March 17, 1962, that (I) (we) last saw the deceased alive on March 17, 1962, and that death occured at 12:15 AM from the causes and on the date stated above.

22a. SIGNATURE: Benjamin J. Gilson, M.D.
ATTENDING PHYS. ☐ MED DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: 17 March 1962
22c. PHYSICIAN'S NAME (Type): Benjamin J. Gilson, LT MC USN
22d. ADDRESS: U.S. Naval Hospital, Bethesda, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 3-20-62
23c. NAME OF CEMETERY OR CREMATORY: Arlington National Cemetery
23d. LOCATION (City, town or county) (State): Arlington, Virginia

24. FUNERAL DIRECTOR'S SIGNATURE: M. B. Everly
ADDRESS: Everly-Wheatley Funeral Home, 1500 W. Braddock Rd. Alexandria, Virginia
25a. REC'D BY REGISTRAR DATE: MAR 20 '62
25b. REGISTRAR'S SIGNATURE: [illegible]

# MARYLAND STATE DEPARTMENT OF HEALTH

**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

03403

## CERTIFICATE OF DEATH

03396

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Form 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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1. PLACE OF DEATH
a. COUNTY: MONTGOMERY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): WHEATON
c. LENGTH OF STAY IN 1b: 30 Days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): BELPRE Nursing + Conv. Home, Inc

2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): GAITHERSBURG, Md.
d. STREET ADDRESS: 10 WALKER AVE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: William; Middle: P.; Last: FRANK

4. DATE OF DEATH: Month: 3; Day: 24; Year: 1962

5. SEX: MALE

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 4-8-1883

9. AGE (In years last birthday): 78 yrs. IF UNDER 1 YEAR: Months / Days; IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter

10b. KIND OF BUSINESS OR INDUSTRY: Gen. Construction

11. BIRTHPLACE (County & State, or foreign country): OHIO

12. CITIZEN OF WHAT COUNTRY?: U.S.

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: unknown

17. INFORMANT: Fannie E, Frank — Address: Same as 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a) (b), and (c)]

PART I. DEATH WAS CAUSED BY:
(a) IMMEDIATE CAUSE: Cerebrovascular Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 1 week
DUE TO
(b) Cerebral Arteriosclerosis — Several years
DUE TO
(c) Generalized Arteriosclerosis — Several years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Pulmonary Emphysema

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 1/27/62, 19 to 3/23, 1962 that (I) (we) last saw the deceased alive on 3/23, 1962, and that death occured at 2:45 AM, from the causes and on the date stated above.

22a. SIGNATURE: Max G. Sherer MD — MD — ATTENDING PHYS. ☐ MED. DIRECTOR ☒ STAFF PHYS. ☐

22b. DATE SIGNED: 3/24/62

22c. PHYSICIAN'S NAME (Type): MAX G. SHERER, MD

22d. ADDRESS: 2025 EAST West H'way Silver Spring Md (State)

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: March 27 1961

23c. NAME OF CEMETERY OR CREMATORY: Laytonsville

23d. LOCATION (City, town or county): Laytonsville Md.

24. FUNERAL DIRECTOR'S SIGNATURE: Francis H. Barber — ADDRESS: Laytonsville, Md.

25a. REC'D BY REGISTRAR — DATE: MAR 28 '62

25b. REGISTRAR'S SIGNATURE: Clifton S. Thomas

VR A15 (4)
15M 7/61

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03404 **CERTIFICATE OF DEATH** 03397

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SILVER SPRING
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): DELPRE NURSING HOME

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: D.C.
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): WASHINGTON
d. STREET ADDRESS: 4500 CONN. AVE. N.W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First PHILIP [redacted] Middle Last FRANKS

4. DATE OF DEATH: Month 3 Day 7 Year 1962

5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: JULY-31-1902
9. AGE (In years last birthday): 59 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): JEWELER
10b. KIND OF BUSINESS OR INDUSTRY: –
11. BIRTHPLACE (County & State, or foreign country): LONDON, ENGLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: MAX FRANKS
14. MOTHER'S MAIDEN NAME: UNKNOWN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO
(If yes give war or dates of service): –
16. SOCIAL SECURITY NO.: 177-40-7766
17. INFORMANT: LILY FRANKS Address: 4500 CONN. AVE. N.W.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
(a) IMMEDIATE CAUSE: 163 X CEREBRAL Metastasis — INTERVAL BETWEEN ONSET AND DEATH: 3 Months
DUE TO
(b) CANCER of the LUNG — 1 year
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Metastatic Disease to other portions of Lung

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from December 24 1961 to March 7 1962 that (I) (we) last saw the deceased alive on March 7 1962 and that death occured at 4:15 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Max G Sherer M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☑ STAFF PHYS. ☐
22b. DATE SIGNED: 3/7/62
22c. PHYSICIAN'S NAME (Type): MAX G SHERER MD
22d. ADDRESS: 2025 Eye Street N.W. Washington, D.C.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 3/11/62
23c. NAME OF CEMETERY OR CREMATORY: NAT'L MEM. PARK
23d. LOCATION (City, town or county): FALLS CHURCH (State) VA.

24. FUNERAL DIRECTOR'S SIGNATURE: [illegible]
ADDRESS: 717 [illegible]
25a. REC'D BY REGISTRAR DATE MAR 12 '62
25b. REGISTRAR'S SIGNATURE: Clinton S. [illegible]

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed [redacted] 24 hours after death. [redacted] retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely [redacted] by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03405 **CERTIFICATE OF DEATH** 03398

1. PLACE OF DEATH
a. COUNTY: Montgomery
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN this place: 34
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): The Clinical Center, Bethesda 14, Md.

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Virginia
b. COUNTY:
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Edinburg
d. STREET ADDRESS: Route #2, Box 66
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First Ronald Middle Pennywitt Last Funkhouser
4. DATE OF DEATH: Month March Day 7 Year 1962
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: August 19, 1940
9. AGE (in years last birthday): 21 yrs. IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Student
10b. KIND OF BUSINESS OR INDUSTRY: Not employed
11. BIRTHPLACE (County & State, or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: S. Alvin Funkhouser
14. MOTHER'S MAIDEN NAME: Louise Kagey
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
16. SOCIAL SECURITY NO. (If yes give war or dates of service): Not available
17. INFORMANT (Name, address): The Medical Record The Clinical Center, Bethesda 14, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Terato-choriocarcinoma of left testis with carcinomatosis.
DUE TO (b)
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: 4 months

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that ☒ (this hospital) attended the deceased from February 1, 1962 to March 7, 1962 that (☒ (we) last saw the deceased alive on March 7, 1962, and that death occured at 5:30AM from the causes and on the date stated above.

22a. SIGNATURE: Lee H. Porter III M.D.
22b. DATE SIGNED: 3-6-62
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22c. PHYSICIAN'S NAME (Type): George H. Porter, III, M.D.
22d. ADDRESS: The Clinical Center, National Institutes of Health, Bethesda 14, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 3-10-62
23c. NAME OF CEMETERY OR CREMATORY: Bethel
23d. LOCATION (City, town or county) (State): Edinburg Va.

24. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: Lee Funeral Home washington D.C.

25a. REC'D BY REGISTRAR DATE MAR 9 '62
25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03406

## CERTIFICATE OF DEATH

Item 23c, Film G309 3/29/62 iwk
Item 8 Film G310 4/2/62 iwk

03399

1. PLACE OF DEATH
a. COUNTY: Montgomery MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda (Rural)
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): U. S. Naval Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Virginia
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Portsmouth
d. STREET ADDRESS: 918 North Street
e. IS RESIDENCE ON A FARM? YES [ ] NO [X]

3. NAME OF DECEASED (Type or print): First Eugene Middle Franklin Last Gayle Jr.
4. DATE OF DEATH: Month March Day 23 Year 1962
5. SEX: Male
6. COLOR OR RACE: Caucasian
7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: ~~March~~ April 14, 1941
9. AGE (In years last birthday): 21 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Service Man
10b. KIND OF BUSINESS OR INDUSTRY: - - - - -
11. BIRTHPLACE (County & State, or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Eugene F. Gayle
14. MOTHER'S MAIDEN NAME: Ruth E. Swain
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): Yes (If yes give war or dates of service): No
16. SOCIAL SECURITY NO.: - - - -
17. INFORMANT: Hospital Records Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinoma of testis with metastases
DUE TO (b)
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

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INTERVAL BETWEEN ONSET AND DEATH

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES [X] NO [ ]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work [ ] Not While at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (X) (this hospital) attended the deceased from January 8, 1962 to March 23, 1962 that (X) (we) last saw the deceased alive on March 23, 1962, and that death occured at 10:37 AM the causes and on the date stated above.

22a. SIGNATURE: R. T. Brooks Jr. M.D
22b. DATE SIGNED: March 23, 1962
ATTENDING PHYS [ ] MED. DIRECTOR [ ] STAFF PHYS. [X]
22c. PHYSICIAN'S NAME (Type): R. T. BROOKS LT MC USN
22d. ADDRESS: U. S. Naval Hospital, Bethesda, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Mar. 24, 1962
23c. NAME OF CEMETERY OR CREMATORY: Hampton National
23d. LOCATION (City, town or county) (State): Hampton, Virginia

24. FUNERAL DIRECTOR'S SIGNATURE: W. W. Chambers Co.
ADDRESS: W. W. CHAMBERS Funeral Home, 1400 Chapin St., WDC
25a. REC'D BY REGISTRAR DATE MAR 27 '62
25b. REGISTRAR'S SIGNATURE: Arthur S. Thomas

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7.61

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03407

## CERTIFICATE OF DEATH

Item 8 Film 6508 5/12/62 iwk

03400

**1. PLACE OF DEATH**
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN this place: 2 hrs. 15 min.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Suburban

**2. USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
a. STATE: Md.
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Gaithersburg
d. STREET ADDRESS: Asbury
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

**3. NAME OF DECEASED** (Type or print): First: Blanche — Middle: E. — Last: Coleman

**4. DATE OF DEATH**: Month: March — Day: 4 — Year: 1962

**5. SEX**: Female

**6. COLOR OR RACE**: White

**7. MARRIED** ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

**8. DATE OF BIRTH**: 8/19/1879

**9. AGE** (In years last birthday): 82 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): Homemaker

**10b. KIND OF BUSINESS OR INDUSTRY**:

**11. BIRTHPLACE** (County & State, or foreign country): Pennsylvania

**12. CITIZEN OF WHAT COUNTRY?**: U.S.A.

**13. FATHER'S NAME**: John Lowery

**14. MOTHER'S MAIDEN NAME**: Sarah Rhodes

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unkown): No — (If yes give were or dates of service)

**16. SOCIAL SECURITY NO.**:

**17. INFORMANT**: Francis Porter Howson, Md. — Address: 269 - Ridge Ave.

**18. CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Congestive Heart Failure
DUE TO (b): Arteriosclerotic Heart Disease
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: 6 hours

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

**19. WAS AUTOPSY PERFORMED?** YES ☐ NO ☒

MEDICAL CERTIFICATION

**20a. ACCIDENT WAS UNDERLYING** ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER):

**20b. DESCRIBE HOW INJURY OCCURED.** (Enter nature of injury in Part I or Part II of item 18.)

**20c. TIME OF INJURY** Hour a.m. p.m. Month, Day, Year 19

**20d. INJURY OCCURRED** While at work ☐ Not While at work ☐

**20e. PLACE OF INJURY** (Home, farm, factory, street, office bldg., etc.)

**20f.** (City or town) (County) (State)

**21. I certify** that ~~I~~ (this hospital) attended the deceased from March 4, 1962 to March 4, 1962, that ~~I~~ (we) last saw the deceased alive on March 4 1962 and that death occured at 6 P.M. from the causes and on the date stated above.

**22a. SIGNATURE**: Robert G. Angle M.D.

**22b. DATE SIGNED**: 3-4-62

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

**22c. PHYSICIAN'S NAME** (Type): Robert G. Angle

**22d. ADDRESS**: 5000 Delray Ave. Bethesda, Md.

**23a. BURIAL, CREMATION, REMOVAL** (Specify): Burial

**23b. DATE THEREOF**: 3-7-62

**23c. NAME OF CEMETERY OR CREMATORY**: Sandymount Church

**23d. LOCATION** (City, town or county): Sandymount (State): Md.

**24. FUNERAL DIRECTOR'S SIGNATURE**: Leo Portner

ADDRESS: 316 E. Diamond Ave. Gaithersburg, Md.

**25a. REC'D BY REGISTRAR** DATE: MAR 7 '62

**25b. REGISTRAR'S SIGNATURE**: Arthur S. Kraus

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**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed and filed with the hospital or attending physician within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

FOR STATE HEALTH DEPT.

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03408

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH 03401

1. PLACE OF DEATH
a. COUNTY: Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
c. LENGTH OF STAY IN 1b: 8 yrs
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 11416 Sherrie Lane

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Md
b. COUNTY: Monty
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
d. STREET ADDRESS: 11416 Sherrie Lane
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Marion Middle: Grason-Gibson-Jr. Last: Gibson
4. DATE OF DEATH: Month: Mar Day: 11 Year: 1962
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 9-9-25
9. AGE (In years last birthday): 36 yrs. IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Steam fitter
10b. KIND OF BUSINESS OR INDUSTRY: John Fitzgerald Co.
11. BIRTHPLACE (State or foreign country): Md
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Marion G. Gibson Sr.
14. MOTHER'S MAIDEN NAME: Nellie Gass Gibson
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes give war or dates of service): WWII
16. SOCIAL SECURITY NO.: 220-16-4568
17. INFORMANT: Barbara Gibson (wife) Address: Silver Spring

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary occlusion
4 hrs
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):
INTERVAL BETWEEN ONSET AND DEATH: Sudden
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I **certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from. Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Frank J. Broshart M.D.
EXAMINER'S NAME (Type): FRANK J. BROSHART
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county):
DATE SIGNED: 3-11-62

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 3-14-62
22c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Cemetery
22d. LOCATION (City, town, or country) (State): Suitland Prince George's Co. Md.

23. FUNERAL DIRECTOR: Raymond A. Fiska ADDRESS: 8434 Georgia Ave
Warner E. Pumphrey, Inc. Silver Spring, Maryland
24a. REC'D BY REGISTRAR DATE: MAR 15 '62
24b. REGISTRAR'S SIGNATURE: [illegible]

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any [illegible] necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AISME
SM 9/60

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03409

# MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

03402

1. PLACE OF DEATH a. COUNTY: Montgomery MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Kensington
c. LENGTH OF STAY IN 1b: 13 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Kensington Gardens San.

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: D.C. b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington 47X-5
d. STREET ADDRESS: 5524 9th Street, N.W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3 NAME OF DECEASED (Type or print): First Martin Middle George Last Gilbertson
4 DATE OF DEATH: Month Mar Day 21 Year 1962

5. SEX: male
6. COLOR OR RACE: white
7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 2/22/82
9. AGE (In years last birthday): 80 yrs
IF UNDER 1 YEAR: Months Days; IF UNDER 24 HRS: Hours Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ret.Mgr. Kennedy-Warren Garage
10b. KIND OF BUSINESS OR INDUSTRY:
11 BIRTHPLACE (State or foreign country): Norway
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: George Gilbertson
14. MOTHER'S MAIDEN NAME: Augusta

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 578-05-5687
17 INFORMANT: Mrs. Lucille Dennison, Address 5524 9th St. N.W., Wash,D.C.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Acute Coronary Insufficiency — INTERVAL BETWEEN ONSET AND DEATH: 1 hr

420.1

DUE TO (b) Hypertensive Arteriosclerotic cardiovasc dis. — 6 yrs

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c)

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d INJURY OCCURRED While at work ☐ Not while at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21 I certify that (I) (this hospital) attended the deceased from Jan 29, 1958, to Mar 21, 1962, that (I) (we) last saw the deceased alive on Mar. 20 1962, and that death occurred at 5:40 P.M. from the causes and on the date stated above

22a. SIGNATURE: M F Ottman M.D
ATTENDING PHYS. ☑ MED DIRECTOR ☐ STAFF PHYS. ☐
22b DATE SIGNED: Mar 21, 1962
22c PHYSICIAN'S NAME (Type): M.F.OTTMAN MD
22d ADDRESS: 11800 Ga Ave RS Md

23a. BURIAL, ~~CREMATION~~ REMOVAL (Specify): 
23b. DATE THEREOF: 3/24/62
23c. NAME OF CEMETERY OR CREMATORY: Rock Creek Cemetery
23d. LOCATION (City, town, or county) (State): Washington, D.C.

24 FUNERAL DIRECTOR'S SIGNATURE: The S.H.Hines Co., ADDRESS 2901 14th St. N.W., Wash,D.C.
25a REC'D BY REGISTRAR DATE MAR 22 '62
25b REGISTRAR'S SIGNATURE: Arthur S. Thomas

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death

VR ATS (4)
TSM 9/59

# MARYLAND STATE DEPARTMENT OF HEALTH

**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

03410 **CERTIFICATE OF DEATH** 03403

**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed and filed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal; and in any event, within 72 hours after death.

1. **PLACE OF DEATH**
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): OLNEY
c. LENGTH OF STAY IN 1b: 43 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MONTGOMERY GENERAL HOSPITAL

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: MONTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): DAMASCUS
d. STREET ADDRESS: 24910 WOODFIELD ROAD
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: VIOLA Middle: L. Last: GILLISS

4. **DATE OF DEATH** Month: 3 Day: 14 Year: 19 62

5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 4-9-75
9. AGE (In years last birthday): 86 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED
10b. KIND OF BUSINESS OR INDUSTRY: GOVT. AGRICULTURAL DEPT.
11. BIRTHPLACE (County & State, or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: JOHN S. GILLISS
14. MOTHER'S MAIDEN NAME: HARRIETT LEANAH RICHKETTS
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
16. SOCIAL SECURITY NO. (If yes give war or dates of service): None
17. INFORMANT: HOSPITAL RECORDS Address:

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Emboli, Massive — INTERVAL BETWEEN ONSET AND DEATH

DUE TO (b) Pulmonary Infarct, Multible

DUE TO (c) Thrombosis Deep Femoral Veins

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

460X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I **certify** that (I) (this hospital) attended the deceased from Jan 19 62 to March 14, 1962, that (I) (we) last saw the deceased alive on March 14 19 62, and that death occured at 3:15P M, from the causes and on the date stated above.

22a. SIGNATURE: G F Meadors M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 3/16/62
22c. PHYSICIAN'S NAME (Type): G. F. MEADORS, M.D.
22d. ADDRESS: DAMASCUS, MARYLAND

23a. BURIAL, CREMATION, REMOVAL: Burial
23b. DATE THEREOF: March 18 1962
23c. NAME OF CEMETERY OR CREMATORY: Rockville Union
23d. LOCATION (City, town or county) (State): Rockville Md.

24 FUNERAL DIRECTOR'S SIGNATURE: Francis H. Barber
ADDRESS: Laytonsville, Md.

25a. REC'D BY REGISTRAR DATE MAR 20 '62
25b. REGISTRAR'S SIGNATURE: Arthur S Kraus

VR A15 (4)
15M 7/61

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03411

## CERTIFICATE OF DEATH

03404

**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed in 24 hours after death. Page 4 should be retained by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: MARYLAND
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Suburban Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)
a. STATE: District of Columbia
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington
d. STREET ADDRESS: 3911 Military Rd., N. W.
e. IS RESIDENCE ON A FARM? YES [ ] NO [X]

3. NAME OF DECEASED (Type or print): First MARY Middle MARGARET Last GLESSNER
4. DATE OF DEATH: Month March Day 3, Year 1962
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: Mar.16, 1898
9. AGE (In years last birthday): 63 yrs. IF UNDER 1 YEAR Months 11 Days 17 IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Washington, D. C.
12. CITIZEN OF WHAT COUNTRY? U. S.
13. FATHER'S NAME: William D. McFarland
14. MOTHER'S MAIDEN NAME: Mary Oulihan
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give wars or dates of service): No
16. SOCIAL SECURITY NO.: 579-28-7272
17. INFORMANT: Husband Reu Glessner Address: Same as Item #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

| | | Interval between onset and death |
|---|---|---|
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) | Cerebral hemorrhage | 7 days |
| DUE TO (b) | Metastasis carcinoma to bone & brain | 7 mo. |
| DUE TO (c) | Carcinoma of breast. | |

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work [ ] Not While at work [ ]
20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from April 1, 1939, to March 3, 1962, that (I) (we) last saw the deceased alive on March 1, 1962, and that death occured at 4:45 AM, from the causes and on the date stated above.

22a. SIGNATURE: Gilbert B. Rude M.D.
22b. DATE SIGNED: March 3, 1962
22c. PHYSICIAN'S NAME (Type): GILBERT B. RUDE
ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]
22d. ADDRESS: 3900 Military rd. N.W. DC

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 3/6/62
23c. NAME OF CEMETERY OR CREMATORY: Ft. Lincoln Cemetery
23d. LOCATION (City, town or county) (State): Prince George Co. Md.

24. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: Robert A. Pumphrey, Bethesda, Maryland

25a. REC'D BY REGISTRAR DATE MAR 7 '62
25b. REGISTRAR'S SIGNATURE: [illegible]

VR A15 (4, 1SM 7 61

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03412

## CERTIFICATE OF DEATH

03405

**1. PLACE OF DEATH**
a. COUNTY: Monte,
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Gaithersburg. Rural
c. LENGTH OF STAY IN MARYLAND: 40 yr
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

**2. USUAL RESIDENCE** (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Monte.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Gaithersburg. Rural
d. STREET ADDRESS: LongDraft Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

**3. NAME OF DECEASED** (Type or print): First: Gladys Middle: Josephine Last: Glover

**4. DATE OF DEATH** Month: Mar Day: 24 Year: 1962

**5. SEX**: Female

**6. COLOR OR RACE**: White

**7. MARRIED** ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

**8. DATE OF BIRTH**: Feb 24-1896

**9. AGE** (In years last birthday): 66 yrs. IF UNDER 1 YEAR: Months 1 Days 0 IF UNDER 24 HRS.: Hours Min.

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): House Wife

**10b. KIND OF BUSINESS OR INDUSTRY**: Home Work

**11. BIRTHPLACE** (County & State, or foreign country): San Francisco. Calf,

**12. CITIZEN OF WHAT COUNTRY?**: U S A

**13. FATHER'S NAME**: Charles Burdette

**14. MOTHER'S MAIDEN NAME**: Nettie Shuck

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unkown) (If yes give war or dates of service)

**16. SOCIAL SECURITY NO.**

**17. INFORMANT** Address: Mrs Henry Musser, Gaithersburg. Md.

**MEDICAL CERTIFICATION**

**18. CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CEREBRAL EMBOLUS
DUE TO (b) BRAIN ATROPHY
DUE TO (c) CARCINOMA OF SPINAL CORD

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: ONE DAY / ONE YEAR / SMONTHS

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

**19. WAS AUTOPSY PERFORMED?** YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (~~this hospital~~) attended the deceased from JUNE 23, 1961, to March 24, 1962, that (I) (we) last saw the deceased alive on MARCH 21, 1962 and that death occured at 12:00 AM/PM from the causes and on the date stated above.

22a. SIGNATURE: Gordon S. Rosenberger M D

22b. DATE SIGNED

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22c. PHYSICIAN'S NAME (Type): Gordon S. Rosenberger, M. D.

22d. ADDRESS: 310 W. Montgomery Ave, Rockville, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 3-27-62

23c. NAME OF CEMETERY OR CREMATORY: ~~Park Lawn~~

23d. LOCATION (City, town or county) (State): Rockville. Md.

24 FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Ernest C. Gartner. Gaithersburg. Md.

25a. REC'D BY REGISTRAR DATE MAR 27 '62

25b. REGISTRAR'S SIGNATURE: Arthur L. Thomas

**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. It should be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

YR A15 (4)
15M 9/60

FOR STATE HEALTH DEPT.

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03413 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 03406

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rockville
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 1002 Brice Rd

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Md
b. COUNTY: Monty
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 10 Rockville
d. STREET ADDRESS: 1002 Brice Rd
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Mary Middle: Ellen Last: Golden

4. DATE OF DEATH: Month: Mar Day: 4 Year: 1962

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 2-15-62
9. AGE (In years last birthday): 0 yrs. IF UNDER 1 YEAR: Months 0 Days 19 IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): —
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): DC
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Ralph Golden
14. MOTHER'S MAIDEN NAME: Jewel Kurtz
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wars or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Ralph Golden (father) Address: Stem 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Asphyxia
475X
DUE TO (b): Upper Respiratory Infection
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: Sudden
24 hrs.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Frank J. Broschart M.D
EXAMINER'S NAME (Type): FRANK J. BROSCHART
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county):
DATE SIGNED: 3-4-62

22a. BURIAL, CREMATION, REMOVAL (Specify): Cremation
22b. DATE THEREOF: March 5-1962
22c. NAME OF CEMETERY OR CREMATORY: Lee Crematory
22d. LOCATION (City, town, or country): Washington (State): DC

23. FUNERAL DIRECTOR: Lee Funeral Home
ADDRESS: Washington, DC
24a. REC'D BY REGISTRAR DATE MAR 7 '62
24b. REGISTRAR'S SIGNATURE: Clifford S. Krauss

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any de necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

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# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03414 **CERTIFICATE OF DEATH** 03407

**1. PLACE OF DEATH**
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Kensington
c. LENGTH OF STAY IN 1b: 10 months
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Kensington Gardens Sanitarium

**2. USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
a. STATE: Florida
b. COUNTY: Osceola
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Maitland, Florida
d. STREET ADDRESS: 123 Hollie Court
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

**3. NAME OF DECEASED** (Type or print): First: Victor — Middle: E. — Last: Goodwin

**4. DATE OF DEATH**: Month: March — Day: 11 — Year: 1962

**5. SEX**: Male

**6. COLOR OR RACE**: White

**7. MARRIED** ☑ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

**8. DATE OF BIRTH**: May 11 1879

**9. AGE** (In years last birthday): 82 yrs.

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): Electrical Engineer

**10b. KIND OF BUSINESS OR INDUSTRY**: General Electric Corp.

**11. BIRTHPLACE** (County & State, or foreign country): Minneapolis, Minnesota

**12. CITIZEN OF WHAT COUNTRY?**: U.S.A.

**13. FATHER'S NAME**: Isaac Goodwin

**14. MOTHER'S MAIDEN NAME**: Ann Craik

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unkown): No

**16. SOCIAL SECURITY NO.**: 016-03-5301

**17. INFORMANT**: Edna Goodwin — Address: 123 Hollie Court

**18. CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Congestive Heart Failure
DUE TO (b): Aortic Stenosis
DUE TO (c): Arteriosclerosis

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

INTERVAL BETWEEN ONSET AND DEATH: 10 hours

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Pneumonia, Lobar

**19. WAS AUTOPSY PERFORMED?** YES ☐ NO ☑

**20a. ACCIDENT WAS UNDERLYING** ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

**20b. DESCRIBE HOW INJURY OCCURED.** (Enter nature of injury in Part I or Part II of item 18.)

**20c. TIME OF INJURY** Hour a.m. p.m. — Month, Day, Year 19

**20d. INJURY OCCURRED** While at work ☐ Not While at work ☐

**20e. PLACE OF INJURY** (Home, farm, factory, street, office bldg., etc.)

**20f.** (City or town) (County) (State)

**21. I certify** that (I) (~~this hospital~~) attended the deceased from May, 1961, to March 11, 1962, that (I) (~~we~~) last saw the deceased alive on March 11, 1962, and that death occured at 7:35 P.M., from the causes and on the date stated above.

**22a. SIGNATURE**: John S. Dyer, M.D.

ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐

**22b. DATE SIGNED**: 3/14/62

**22c. PHYSICIAN'S NAME** (Type): Robert F. Dyer MD

**22d. ADDRESS**: 915 19th Street, NW

**23a. BURIAL, CREMATION, REMOVAL** (Specify): burial

**23b. DATE THEREOF**: 3/14/62

**23c. NAME OF CEMETERY OR CREMATORY**: Rock Creek Cemetery

**23d. LOCATION** (City, town or county) (State): Washington, D.C.

**24. FUNERAL DIRECTOR'S SIGNATURE**: The S.H. Hines Company

ADDRESS: 2901 14th St. N.W. Washington 9, D.C.

**25a. REC'D BY REGISTRAR** DATE: MAR 1 1 '62

**25b. REGISTRAR'S SIGNATURE**: Alan L. Thomas

MEDICAL CERTIFICATION

**TO THE ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 1 should be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03415 **CERTIFICATE OF DEATH** 03408

Items 8 & 9 fi.m G309 3/12/62 iwk

**1. PLACE OF DEATH**
a. COUNTY: Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Kensington
c. LENGTH OF STAY: MARYLAND
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 4404 Colfax Street

**2. USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 43 Kensington
d. STREET ADDRESS: 4404 Colfax Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

**3. NAME OF DECEASED** (Type or print): First: Mendez; Middle: ; Last: Gottschalk

**4. DATE OF DEATH**: Month: March; Day: 6; Year: 19 62

**5. SEX**: Male

**6. COLOR OR RACE**: White

**7. MARRIED** ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

**8. DATE OF BIRTH**: 11/20/83 1882

**9. AGE** (In years last birthday): 79 78 yrs.; IF UNDER 1 YEAR: Months 3, Days 16; IF UNDER 24 HRS.: Hours, Min.

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): Ret. Salesman

**10b. KIND OF BUSINESS OR INDUSTRY**: Selling

**11. BIRTHPLACE** (County & State or foreign country): New York

**12. CITIZEN OF WHAT COUNTRY?**: USA

**13. FATHER'S NAME**: Julius Gottschalk

**14. MOTHER'S MAIDEN NAME**: Marie Rammenstein

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unkown) (If yes give year or dates of service): No

**16. SOCIAL SECURITY NO.**: 057-16-8244

**17. INFORMANT** Address: Helen E. Gottschalk, Wife-same 2d

**MEDICAL CERTIFICATION**

**18. CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC CARDIOVASCULAR DIS — INTERVAL BETWEEN ONSET AND DEATH: 4 YEARS.
DUE TO (b)
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
4 22.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Diabetes Mellitus

**19. WAS AUTOPSY PERFORMED?** YES ☐ NO ☒

**20a. ACCIDENT WAS UNDERLYING** ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

**20b. DESCRIBE HOW INJURY OCCURED.** (Enter nature of injury in Part I or Part II of item 18)

**20c. TIME OF INJURY** Hour a.m. p.m. Month, Day, Year 19

**20d. INJURY OCCURRED** While at work ☐ Not While at work ☐

**20e. PLACE OF INJURY** (Home, farm, factory, street, office bldg., etc.)

**20f.** (City or town) (County) (State)

**21. I certify** that (I) (~~this hospital~~) attended the deceased from Oct. 9, 1956 to MAR 6, 1962, that (I) (~~we~~) last saw the deceased alive on MAR 5 1962 and that death occured at . . . M, from the causes and on the date stated above

**22a. SIGNATURE** DeWitt E. DeLawter M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

**22b. DATE SIGNED** 5-6-62

**22c. PHYSICIAN'S NAME** (Type): DeWitt E. DeLawter

**22d. ADDRESS**: 3848 Porter Street, N. W., Wash. DC

**23a. BURIAL, CREMATION, REMOVAL** (Specify): Burial

**23b. DATE THEREOF**: 3/8/62

**23c. NAME OF CEMETERY OR CREMATORY**: Parklawn Cemetery

**23d. LOCATION** (City, town or county) (State): Rockville, Maryland

**24 FUNERAL DIRECTOR'S SIGNATURE** ADDRESS: Robert A. Pumphrey, Bethesda, Maryland

**25a. REC'D BY REGISTRAR** DATE MAR 9 '62

**25b. REGISTRAR'S SIGNATURE** Arthur S. Thomas

**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed 24 hours after death. Page 4 must be retained by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03416 **CERTIFICATE OF DEATH** 03409

**1. PLACE OF DEATH**
a. COUNTY: Montgomery
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: 26 years
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): 7607 Eastern Avenue

**2. USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park, Maryland
d. STREET ADDRESS: 7607 Eastern Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Phillip Middle: Henry Last: Goundie
4. DATE OF DEATH: Month: March Day: 26 Year: 1962
5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: June 5, 1882
9. AGE (In years last birthday): 79 yrs. IF UNDER 1 YEAR Months Days; IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Floor Manager
10b. KIND OF BUSINESS OR INDUSTRY: Hecht Company
11. BIRTHPLACE (State or foreign country): Pennsylvania
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Phillip Goundie
14. MOTHER'S MAIDEN NAME: Mary V. Petty
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No None
16. SOCIAL SECURITY NO.: 578-10-3101
17. INFORMANT: Mrs. Iola C.V. Case Address: 7607 Eastern Ave., Takoma Park, Md.

**MEDICAL CERTIFICATION**

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): UREMIA — INTERVAL BETWEEN ONSET AND DEATH: 1 wk.
DUE TO (b): Nephrosclerosis — 1 yr.
DUE TO (c): Arteriosclerosis — 10 yrs.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c): Congestive Heart Failure

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I **certify** that (I) (this hospital) attended the deceased from June, 1960, to 3/25, 1962, that (I) (we) last saw the deceased alive on 3/25 1962, and that death occured at 3:00 AM, from the causes and on the date stated above.

22a. SIGNATURE: Sanford J. Randall M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 3/26/62
22c. PHYSICIAN'S NAME (Type): S. J. RANDALL, M.D.
22d. ADDRESS: 3636 16 ST. N.W. D.C.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 3-29-62
23c. NAME OF CEMETERY OR CREMATORY: Fort Lincoln Cemetery
23d. LOCATION (City, town or county) (State): Prince George's Co., Maryland

24 FUNERAL DIRECTOR'S SIGNATURE: Raymond C. Zeller ADDRESS: 8434 Georgia Ave.
Warner E. Pumphrey, Inc. Silver Spring, Maryland
25a. REC'D BY REGISTRAR DATE: MAR 30 '62
25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03417

## CERTIFICATE OF DEATH

Reg. Dist. No. 03410

1 PLACE OF DEATH
a. COUNTY MONTGOMERY MARYLAND

2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission)
a. STATE Maryland b. COUNTY Montgomery

b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase

c. LENGTH OF STAY IN 1b

c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase

d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 6609 Brookville Road

d. STREET ADDRESS 6609 Brookville Road

e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First HARVEY Middle BEECHER Last GRAM

4. DATE OF DEATH Month MAR. Day 26 Year 1962

5 SEX MALE

6 COLOR OR RACE CAU.

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8 DATE OF BIRTH NOV 24, 1869

9. AGE (In years last birthday) 92 yrs

IF UNDER 1 YEAR: Months Days

IF UNDER 24 HRS: Hours Min.

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired

10b. KIND OF BUSINESS OR INDUSTRY U.S. War Dept.

11. BIRTHPLACE (State or foreign country) Ohio

12 CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME David Gram

14. MOTHER'S MAIDEN NAME Margaret Dell

15 WAS DECEASED EVER IN U. S ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) - - -

16. SOCIAL SECURITY NO - - - - -

INFORMANT Harvey B. Gram, Jr. Address 5804 Overlea Road Washington 16, D. C.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic brain syndrome — INTERVAL BETWEEN ONSET AND DEATH 5 MONS.

DUE TO (b) Cerebro-vascular Thrombosis — 6 MONS.

DUE TO (c) Cerebral Arteriosclerosis — UNKNOWN

332X

Conditions, if any which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from AUG 18, 1961, to MAR 26, 1962 that I last saw the deceased alive on MAR 26, 1962, and that death occurred at 6:40 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE Robert S. Poole MD ADDRESS (Street, city or town, state) 4501 CONN AVE DATE SIGNED 3/26/62

PHYSICIAN'S NAME (Type) ROBERT S. POOLE, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial

22b. DATE THEREOF 3-29-1962

22c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery

22d LOCATION (City, town, or county) (State) Washington, D. C.

23. FUNERAL DIRECTOR'S SIGNATURE Joseph Gawler & Sons 1726-1728 Conn. Ave. Wash. 6, D.C. ADDRESS

24a REC'D BY REGISTRAR DATE MAR 29 '62

24b. REGISTRAR'S SIGNATURE Arthur E. Hume

TO HOSPITAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

03418 03411

1. PLACE OF DEATH a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Kensington
c. LENGTH OF STAY IN Ib
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Kensington Sanitarium

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: D.C.
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington, D.C.
d. STREET ADDRESS: 515 Quintana Place N.W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First Susie Middle E Last Duffie
4. DATE OF DEATH: Month March Day 19 Year 1962
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐
8. DATE OF BIRTH: July 20, 1879
9. AGE (In years last birthday): 82 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Homemaker
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (County & State, or foreign country): Madison, Va.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Benjamin F. Turner
14. MOTHER'S MAIDEN NAME: Ella Sullivan
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes give wars or dates of service)
16. SOCIAL SECURITY NO.: no
17. INFORMANT: Dorothy E. Watson — Address: same as #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia, Bilateral — INTERVAL BETWEEN ONSET AND DEATH: 5 days
4-14-3X
DUE TO (b) Congestive Heart Failure — 7 days
DUE TO (c) Hypertensive & Arteriosclerotic Heart Disease — 4 years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (~~this hospital~~) attended the deceased from Feb. 28, 1949 to March 17, 1962 that (I) (~~we~~) last saw the deceased alive on March 18, 196- and that death occured at 7:25 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Horace H Custis Jr.
M.D. ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 3/19/62
22c. PHYSICIAN'S NAME (Type): Horace H. Custis, Jr.
22d. ADDRESS: 1852 Columbia Rd., N.W., Washington, D.C.

23a. BURIAL, CREMATION, REMOVAL (Specify): burial
23b. DATE THEREOF: 3/22/62
23c. NAME OF CEMETERY OR CREMATORY: Rock Creek Cemetery
23d. LOCATION (City, town or county) (State): Washington, D.C.

24. FUNERAL DIRECTOR'S SIGNATURE: The S.H. Hines Company
ADDRESS: 2901 14th St. N.W. Washington 9, D.C.
25a. REC'D BY REGISTRAR DATE MAR 21 '62
25b. REGISTRAR'S SIGNATURE: Calvin S. Hines

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 should be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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FOR STATE HEALTH DEPT.

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03419 Item 2 Film G910 4/3/62 1wk

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03412

1. PLACE OF DEATH
a. COUNTY: Montgomery MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Potomac
c. LENGTH OF STAY IN 1b: 2 yrs
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Potomac Manor Rest Home

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Md
b. COUNTY: Montg. Co.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Potomac Hyattsville
d. STREET ADDRESS: 5451 Newton St. Apt.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Anne Middle: D. Last: Grigsby

4. DATE OF DEATH: Month: Mar Day: 8 Year: 1962

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 12-21-1874
9. AGE (In years last birthday): 87
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Va.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Alfred Askew
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Rest Home Record Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Congestive heart failure — INTERVAL BETWEEN ONSET AND DEATH: sudden
DUE TO
(b) Chronic Myocarditis — month
DUE TO
(c)

422.2

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Bronchopneumonia 2 wks ago

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Frank J. Broschart M.D
EXAMINER'S NAME (Type): FRANK J. Broschart
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county):
DATE SIGNED: 3-8-62

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Mar. 12-62
22c. NAME OF CEMETERY OR CREMATORY: Forest Lawn Cemetery
22d. LOCATION (City, town, or country) (State): Richmond Va.

23. FUNERAL DIRECTOR: SIMMONS BROS.
ADDRESS: 1661 - GOOD HOPE RD. S.E. WASHINGTON D.C.
24a. REC'D BY REGISTRAR: DATE MAR 12 '62
24b. REGISTRAR'S SIGNATURE: Gertrude E. Thomas

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any [illegible] necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AISME
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FOR STATE HEALTH DEPT.

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AISME
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# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03420 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 03413

1. PLACE OF DEATH
a. COUNTY: Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
MARYLAND
c. LENGTH OF STAY IN 1b: 3½ hrs
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Suburban

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: D.C.
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington
d. STREET ADDRESS: 3908 Morrison St.,
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Larry Middle: T. Last: Gurley
4. DATE OF DEATH: Month: March Day: 14 Year: 1962
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒
8. DATE OF BIRTH: FEB 24, 1896
9. AGE (In years last birthday): 66 yrs. IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter (Ret.)
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Alabama
12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Unknown
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): I
16. SOCIAL SECURITY NO.: 526 07 6928
17. INFORMANT: Charles G. Quinn Address: 118-2nd St. Greenwood Acres Kensington Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Massive Gangrene Intestinal tract
5702
DUE TO (b) Mesenteric Thrombosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)
INTERVAL BETWEEN ONSET AND DEATH: 3 days
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐
20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinion death resulted from Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Frank J. Broschart M.D.
EXAMINER'S NAME (Type): Dr. Frank Broschart
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town or county)
DATE SIGNED: March 14, 1962

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 3-19-62
22c. NAME OF CEMETERY OR CREMATORY: Arlington National
22d. LOCATION (City, town, or country) (State): Arlington, Virginia
23. FUNERAL DIRECTOR: W-W Chambers Co. ADDRESS: 5801 Cleveland Ave Riverdale Md
24a. REC'D BY REGISTRAR DATE: MAR 19 '62
24b. REGISTRAR'S SIGNATURE

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03421 **CERTIFICATE OF DEATH** 03414

1. PLACE OF DEATH
a. COUNTY: Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 5½ days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Suburban

MARYLAND

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Mont.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
d. STREET ADDRESS: 5073 River Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Lewis; Middle: M.; Last: Hall
4. DATE OF DEATH: Month: March; Day: 22; Year: 1962
5. SEX: Male
6. COLOR OR RACE: Colored
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 6/25/29
9. AGE (In years last birthday): 32 yrs. IF UNDER 1 YEAR: Months / Days; IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Truck driver
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Nathan Hall
14. MOTHER'S MAIDEN NAME: Rachael Thompson
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): no (If yes give were or dates of service)
16. SOCIAL SECURITY NO.: 218-20-1697
17. INFORMANT: wife; Address: same as above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Subarachnoidal hemorrhage, right
DUE TO (b): Ruptured cerebral aneurysm, middle cerebral artery, right
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) ☐
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m.; Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from March 16, 1962 to March 22, 1962 that (I) (we) last saw the deceased alive on Mar. 21, 1962, and that death occured at 2:45 A.M. from the causes and on the date stated above.

22a. SIGNATURE: John L. Lord M.D.
ATTENDING PHYS ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type): Dr. John Lord
22d. ADDRESS:

23a. BURIAL, CREMATION, REMOVAL (Place?): Burial
23b. DATE THEREOF: 3/25/62
23c. NAME OF CEMETERY OR CREMATORY: Ebnezer Church.,
23d. LOCATION (City, town or county): Centerville, Md. (State)

24. FUNERAL DIRECTOR'S SIGNATURE: Robert L. Snowden.
ADDRESS: Rockville, Md.

25a. REC'D BY REGISTRAR DATE MAR 27 '62
25b. REGISTRAR'S SIGNATURE: Clifton S. Thomas

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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FOR STATE HEALTH DEPT.

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any [illegible] is necessary, please execute [illegible] certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AISME
5M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03422 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 03415

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN this place: D.O.A.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Wash San + Hosp

2. USUAL RESIDENCE (Where deceased lived, if institution, last residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
d. STREET ADDRESS: 9511 Colesville Rd
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: William — Middle: Edgar — Last: Hallman

4. DATE OF DEATH: Month: 3 — Day: 6 — Year: 1962

5. SEX: M

6. COLOR OR RACE: Wh

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 1-8-88

9. AGE (In years last birthday): 74 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Motion Picture

10b. KIND OF BUSINESS OR INDUSTRY: Projectionist

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Martin Hallman

14. MOTHER'S MAIDEN NAME: Annie Gardner

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No — (If yes give war or dates of service)

16. SOCIAL SECURITY NO.: 577-05-0631

17. INFORMANT: Mrs. George R. Muschlitz, 104 Franklin Ave., Address Silver Spring, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: Sudden
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ — Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Frank J. Broschart M D

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED: 3-7-62

EXAMINER'S NAME (Type): FRANK J. BROSCHART

Address (Street, city, town, or county)

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 22b. DATE THEREOF: March 9, 1962 — 22c. NAME OF CEMETERY OR CREMATORY: Fort Lincoln Cemetery — 22d. LOCATION (City, town, or county) (State): Prince George's County, Md.

23. FUNERAL DIRECTOR: Raymond A. Zisse — ADDRESS: Warner E. Pumphrey, Inc., Silver Spring, Md.

24a. REC'D BY REGISTRAR: DATE MAR 9 '62

24b. REGISTRAR'S SIGNATURE: Arthur E. Krause

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03423 **CERTIFICATE OF DEATH** 03416

Item 9 Film G310 4/2/62 mh

**1. PLACE OF DEATH**
a. COUNTY: Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda, Maryland
c. LENGTH OF STAY IN 1b: 30 hrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Resmor Hospital

**2. USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
a. STATE: Virginia
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Alexandria,
d. STREET ADDRESS: 11 E. Walnut St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

**3. NAME OF DECEASED** (Type or print): First: EDWARD Middle: AUGUSTUS Last: HAMILTON

**4. DATE OF DEATH**: Month: MARCH Day: 24 Year: 1962

**5. SEX**: MALE
**6. COLOR OR RACE**: WHITE
**7. MARRIED** ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐
**8. DATE OF BIRTH**: Aug. 18, 1885
**9. AGE** (In years last birthday): 77 yrs.
IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hours: Min.:

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): Insurance Broker
**10b. KIND OF BUSINESS OR INDUSTRY**:
**11. BIRTHPLACE** (County & State, or foreign country): New York, N.Y.
**12. CITIZEN OF WHAT COUNTRY?**: U.S.

**13. FATHER'S NAME**: William Hamilton
**14. MOTHER'S MAIDEN NAME**: Poole

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unkown): Yes
(If yes give war or dates of service): W W I
**16. SOCIAL SECURITY NO.**:
**17. INFORMANT**: John Hamilton - Son - 144 D S + S.E. Wash 3 D.C.
Address:

**18. CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Congestive heart failure
DUE TO (b): Arteriosclerotic hypertensive heart disease
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I.(a): Renal failure due to arteriolonephrosclerosis

**19. WAS AUTOPSY PERFORMED?** YES ☒ NO ☐

**20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)**:
**20b. DESCRIBE HOW INJURY OCCURRED** (Enter nature of injury in Part I or Part II of item 18.):
**20c. TIME OF INJURY** Hour a.m. p.m. Month, Day, Year 19
**20d. INJURY OCCURRED** While at work ☐ Not While at work ☐
**20e. PLACE OF INJURY** (Home, farm, factory, street, office bldg., etc.):
**20f.** (City or town) (County) (State)

**21. I certify** that (I) (~~We certify~~) attended the deceased from March 23, 1962 to March 24, 1962 that (I) (~~We~~) last saw the deceased alive on March 24, 1962, and that death occured at 5:12 AM, from the causes and on the date stated above.

**22a. SIGNATURE**: Michael M. Dobridge M.D.
ATTENDING PHYS. ☒ ~~MED~~ DIRECTOR ☐ STAFF PHYS. ☐
**22b. DATE SIGNED**: March 23, 1962
**22c. PHYSICIAN'S NAME** (Type): Michael Dobridge
**22d. ADDRESS**: 10620 Georgia Ave Silver Springs Md.

**23a. BURIAL, CREMATION, REMOVAL** (Specify): Burial
**23b. DATE THEREOF**: 3/27/62
**23c. NAME OF CEMETERY OR CREMATORY**: Arlington National
**23d. LOCATION** (City, town or county) (State): Arlington, Va.

**24. FUNERAL DIRECTOR'S SIGNATURE**: James T. Ryan Inc.
ADDRESS: 317 Penn. Ave. S.E.
**25a. REC'D BY REGISTRAR** DATE MAR 27 '62
**25b. REGISTRAR'S SIGNATURE**: Carlton S. Turner

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1

03424

# MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

03417

1. PLACE OF DEATH
a. COUNTY: Montgomery MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Kensington
c. LENGTH OF STAY IN 1b: 3 weeks
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: LeDeau Gardens

2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
d. STREET ADDRESS: 2100 Hildarose Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Virginia Middle: C. Last: Harding

4. DATE OF DEATH: Month: March Day: 12 Year: 1962

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Jan. 9, 1883
9. AGE (Last birthday) 79 yrs. IF UNDER 1 YEAR: Months 2 Days Hours Min IF UNDER 24 HRS.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: own home
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: George Henry Culver
14. MOTHER'S MAIDEN NAME: Caroline D. Graf

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service): NONE
16. SOCIAL SECURITY NO.: none
17. INFORMANT: Kenneth Culver, Address: 7206 Honeywell La., Bethesda, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral Vascular Accident — INTERVAL BETWEEN ONSET AND DEATH: 2 wks
DUE TO
(b) Hypertension — 4 yrs
DUE TO
(c) Arteriosclerosis — 7 yrs

33 IX

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d INJURY OCCURRED While at work ☐ Not while at work ☐
20e PLACE OF INJURY (Home farm, factory street, office bldg., etc.)
20f. (City or town) (County) (State)

21 I certify that (I) (~~this hospital~~) attended the deceased from June, 1960, to Mar. 12, 1962, that (I) (~~we~~) last saw the deceased alive on Mar. 12 1962, and that death occurred at 9:30 P.M., from the causes and on the date stated above

22a SIGNATURE: John Lawrence Avery M.D.
ATTENDING PHYS. ☒ MED DIRECTOR ☐ STAFF PHYS ☐
22b DATE SIGNED: 3-12-62
22c PHYSICIAN'S NAME (Type): John Lawrence Avery, MD.
22d ADDRESS: 10110 Georgia Ave., Silver Spring Md.

23a BURIAL, CREMATION, REMOVAL (Specify): Burial
23b DATE THEREOF: March 15, 1962
23c NAME OF CEMETERY OR CREMATORY: Colesville Cemetery
23d LOCATION (City, town, or county) (State): Colesville, Montgomery Co., Md.

24 FUNERAL DIRECTOR'S SIGNATURE: Raymond Q. Yoka
ADDRESS: 8434 Georgia Ave.
Warner E. Pumphrey, Inc., Silver Spring, Md.
REC'D BY REGISTRAR DATE: MAR 15 '62
25b REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned to hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death

VR A15 (4) 15M 9/59

1

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03425 **CERTIFICATE OF DEATH** 03418

1. PLACE OF DEATH
a. COUNTY: Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Brookeville
c. LENGTH OF STAY IN 1b: 25 yrs
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

MARYLAND

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Brookeville
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Lillie Middle: May Last: HARVEY
4. DATE OF DEATH: Month: March Day: 2 Year: 1962
5. SEX: Female
6. COLOR OR RACE: Wh.
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Dec. 8, 1874
9. AGE (In years last birthday): 87 yrs. IF UNDER 1 YEAR: Months Days. IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (City & State or foreign country): Frederick Cty. Md.
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME: Carlton Edward OLAND
14. MOTHER'S MAIDEN NAME: Margaret Ann CRAVER
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: none.
17. INFORMANT: C. W. Harvey Address: Brookeville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) Cerebral hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 4 hours
DUE TO (b) Cerebral arteriosclerosis — years
DUE TO (c) Arteriosclerosis — years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c): —

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) —
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from ..... 1962 to Mar. 2, 1962, that (I) (we) last saw the deceased alive on Mar 2 1962, and that death occured at 11:30 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Richard A. Yates MD M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 3/2/62
22c. PHYSICIAN'S NAME (Type): Richard A. YATES
22d. ADDRESS: OLNEY, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: March 5 1962
23c. NAME OF CEMETERY OR CREMATORY: St. Johns
23d. LOCATION (City, town or county): Olney (State): Md.

24. FUNERAL DIRECTOR'S SIGNATURE: Francis H. Barber
ADDRESS: Laytonsville, Md.
25a. REC'D BY REGISTRAR DATE MAR 6 '62
25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 should be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

03426 **CERTIFICATE OF DEATH** 03419

**1. PLACE OF DEATH**
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Kensington
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Carroll Hall Nursing Home-Kensington

**2. USUAL RESIDENCE** (Where deceased lived, If Institution, Residence before admission)
a. STATE: Maryland
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
d. STREET ADDRESS: North Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

**3. NAME OF DECEASED** (Type or print): First CLARA Middle Alice Last HAYNIE

**4. DATE OF DEATH** Month March Day 23 Year 1962

**5. SEX:** Female

**6. COLOR OR RACE:** White

**7. MARRIED** ☐ **NEVER MARRIED** ☒ **WIDOWED** ☐ **DIVORCED** ☐

**8. DATE OF BIRTH:** 1/20/1874

**9. AGE** (In years last birthday): 88 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): Nurse

**10b. KIND OF BUSINESS OR INDUSTRY:**

**11. BIRTHPLACE** (County & State, or foreign country): Virginia

**12. CITIZEN OF WHAT COUNTRY?** U.S.A.

**13. FATHER'S NAME:** John Haynie

**14. MOTHER'S MAIDEN NAME:** Elizabeth Berry

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unkown): No

**16. SOCIAL SECURITY NO.** (If yes give war or dates of service): None

**17. INFORMANT** Address: Bessie Johnston-2629 Henderson-Silver Spring

**MEDICAL CERTIFICATION**

**18. CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC HEART DISEASE — INTERVAL BETWEEN ONSET AND DEATH

420.0

DUE TO (b) ESSENTIAL HYPERTENSION

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) GENERALIZED ARTERIOSCLEROSIS

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): SENILITY

**19. WAS AUTOPSY PERFORMED?** YES ☐ NO ☒

**20a. ACCIDENT WAS UNDERLYING** ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

**20b. DESCRIBE HOW INJURY OCCURRED.** (Enter nature of injury in Part I or Part II of item 18.)

**20c. TIME OF INJURY** Hour a.m. p.m. Month, Day, Year 19

**20d. INJURY OCCURRED** While at work ☐ Not While at work ☐

**20e. PLACE OF INJURY** (Home, farm, factory, street, office bldg., etc.)

**20f.** (City or town) (County) (State)

**21. I certify** that (I) (~~this hospital~~) attended the deceased from JAN. 24, 1957 to March 23, 1962, that (I) (~~we~~) last saw the deceased alive on March 23, 1962, and that death occured at 8:10 P.M., from the causes and on the date stated above.

**22a. SIGNATURE** Menzie Lowdan M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

**22b. DATE SIGNED** March 23 62

**22c. PHYSICIAN'S NAME** (Type)

**22d. ADDRESS** 5206 Norway Dr. Chevy Chase, Md.

**23a. BURIAL, CREMATION, REMOVAL** (Specify): Burial

**23b. DATE THEREOF:** 3/26/62

**23c. NAME OF CEMETERY OR CREMATORY:** Loudon Park Cemetery

**23d. LOCATION** (City, town or county) (State): Baltimore, Maryland

**24 FUNERAL DIRECTOR'S SIGNATURE** Ellsworth Armacost

**ADDRESS** Ellsworth Armacost-4600 Liberty Hghts. Avenue

**25a. REC'D BY REGISTRAR** DATE MAR 27 '62

**25b. REGISTRAR'S SIGNATURE** Clifton L. Thomas

**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03427 **CERTIFICATE OF DEATH** 03420

1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wheaton
c. LENGTH OF STAY IN 1b 15 mo.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Wheaton, Nursing Home

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Md
b. COUNTY Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DAMASCUS
d. STREET ADDRESS 25705 Wright Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First: MARY Middle: Welsh Last: HENDERSON

4. DATE OF DEATH Month: MAR. Day: 31 Year: 1962

5. SEX FEMALE
6. COLOR OR RACE W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH MAY 8 - 1899
9. AGE (In years last birthday) 82 yrs. IF UNDER 1 YEAR: Months / Days; IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY ------
11. BIRTHPLACE (County & State, or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME WARNER Welsh
14. MOTHER'S MAIDEN NAME Clara Adams

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)
16. SOCIAL SECURITY NO. Yes Unknown
17. INFORMANT Address: Mrs. Anne Lindsay-Daughter-same 2d

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial failure — INTERVAL BETWEEN ONSET AND DEATH: 2 hrs.

DUE TO (b) Coronary Stenosis + Insufficiency — 4 years

DUE TO (c) Arteriosclerotic Cardiovascular disease — 10 years

421

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Hypertension. Debility. Senile Brain Syndrome

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) ~~(this hospital)~~ attended the deceased from Sept 19 58 to Mar 31 1962, that (I) (we) last saw the deceased alive on Mar 31 1962, and that death occured at 1:15 p.m., from the causes and on the date stated above.

22a. SIGNATURE James E. Gannon Jr. M.D.
22b. DATE SIGNED
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22c. PHYSICIAN'S NAME (Type) JAMES A. GANNON Jr M.D.
22d. ADDRESS 3141-34th St. N.W.

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE THEREOF 4/5/62
23c. NAME OF CEMETERY OR CREMATORY Hyattstown Ch. Cem.
23d. LOCATION (City, town or county) (State) Hyattstown, Maryland

24 FUNERAL DIRECTOR'S SIGNATURE ADDRESS Robert A. Pumphrey, Bethesda, Maryland
25a. REC'D BY REGISTRAR DATE APR 6 '62
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed in 24 hours after death. Page 4 should be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03428 **CERTIFICATE OF DEATH** 03421

Item 20, rim data 2/27/62 jwk

1. PLACE OF DEATH
a. COUNTY: Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda (Rural)
c. LENGTH OF STAY IN 1b: 9 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): U. S. Naval Hospital

MARYLAND

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Kentucky
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Valley Station
d. STREET ADDRESS: 4806 Seville Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Lola Middle: Faye Last: Henning

4. DATE OF DEATH: Month: March Day: 20, Year: 1962

5. SEX: Female
6. COLOR OR RACE: Caucasian
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: June 18, 1955
9. AGE (In years last birthday): 6 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Child
10b. KIND OF BUSINESS OR INDUSTRY: - - - - - - -
11. BIRTHPLACE (County & State, or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Jack Hardin Henning
14. MOTHER'S MAIDEN NAME: Anna Mildred Drane
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service): - - - - - - -
16. SOCIAL SECURITY NO.: - - - - - - -
17. INFORMANT: FATHER: Jack H. Henning, Address: Same as #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) hemorrhage, gastrointestinal
DUE TO (b) rhabdomyosarcoma, generalized
DUE TO (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

1977

INTERVAL BETWEEN ONSET AND DEATH: 4 Hours

PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that ☒ (this hospital) attended the deceased from March 10, 1962 to March 20, 1962 that ☒ (we) last saw the deceased alive on March 20, 1962, and that death occured at 10:07 from the causes and on the date stated above.

22a. SIGNATURE: Robert V. Rack M.D.
22b. DATE SIGNED: March 20, 1962
ATTENDING PHYS. ☐ MED DIRECTOR ☐ STAFF PHYS. ☒
22c. PHYSICIAN'S NAME (Type): ROBERT V. RACK LT MC USN
22d. ADDRESS: U. S. Naval Hospital, Bethesda, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Mar. 24, 1962
23c. NAME OF CEMETERY OR CREMATORY: Kingswood
23d. LOCATION (City, town or county) (State): Kingswood, Kentucky

24. FUNERAL DIRECTOR'S SIGNATURE: Tyson Wheeler
Tyson-Wheeler Funeral Home, Rockville Pike, Rockville, Md.

25a. REC'D BY REGISTRAR DATE MAR 22 '62
25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed in 24 hours after death. Page 4 is to be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7 61

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03429 **CERTIFICATE OF DEATH** 03422

Item 1c Film G310 4/2/02 mh

M

1. PLACE OF DEATH
a. COUNTY: Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN MARYLAND: ~~15~~ 16 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): The Clinical Center, Bethesda 14, Md.

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
d. STREET ADDRESS: 4612 South Chelsea Lane
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Pearl; Middle: Ruby; Last: Hertz

4. DATE OF DEATH: Month: March; Day: 19; Year: 1962

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: February 24, 1910

9. AGE (In years last birthday): 52 yrs.

IF UNDER 1 YEAR: Months / Days

IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Social Worker

10b. KIND OF BUSINESS OR INDUSTRY: Welfare

11. BIRTHPLACE (County & State, or foreign country): Illinois

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Mose Fennell

14. MOTHER'S MAIDEN NAME: Minnie Johnson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No

16. SOCIAL SECURITY NO.: None

17. INFORMANT: "The Medical Record" The Clinical Center, Bethesda 14, Maryland

I

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

(a) IMMEDIATE CAUSE: Acute pulmonary infarct — INTERVAL BETWEEN ONSET AND DEATH: 10.0

DUE TO

(b) Chronic cor pulmonale — 24 years

DUE TO

(c) Scleroderma — 24 years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (☒ (this hospital) attended the deceased from March 3, 1962 to March 19, 1962, that (☒ (we) last saw the deceased alive on March 19 1962, and that death occured at 11:00AM, from the causes and on the date stated above.

22a. SIGNATURE: Elliot Weser, M.D. M.D.

22b. DATE SIGNED: 3/19/62

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☑

22c. PHYSICIAN'S NAME (Type): Elliot Weser, M.D.

22d. ADDRESS: The Clinical Center, National Institutes of Health, Bethesda 14, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Cremation

23b. DATE THEREOF: 3/20/62

23c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Crematory

23d. LOCATION (City, town or county) (State): Suitland, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE / ADDRESS: Robert A. Pumphrey, Bethesda, Maryland

25a. REC'D BY REGISTRAR: DATE MAR 22 '62

25b. REGISTRAR'S SIGNATURE: Arthur S. Kruse

**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03430 **CERTIFICATE OF DEATH** 03423

M

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): TAKOMA PARK
c. LENGTH OF STAY IN 1b: 7 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): WASHINGTON SAN. + HOSPITAL
MARYLAND

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: NEW YORK
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BATAVIA
d. STREET ADDRESS: 88 MAIN ST
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

I

3. NAME OF DECEASED (Type or print): First IVA Middle GRACE Last HESS

4. DATE OF DEATH: Month 3 Day 26 Year 1962

5. SEX: FE

6. COLOR OR RACE: WH

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 10/29/86

9. AGE (In years last birthday): 75 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Pa

12. CITIZEN OF WHAT COUNTRY? Amer

13. FATHER'S NAME: William Hoover

14. MOTHER'S MAIDEN NAME: Elizabeth Johnson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)

16. SOCIAL SECURITY NO.

17. INFORMANT, Address: Hospital RECORDS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CHOLEMIC NEPHROSIS AND UREMIA

INTERVAL BETWEEN ONSET AND DEATH: 2 WEEKS

DUE TO (b)

DUE TO (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

5 91X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e): CHOLECYSTOTOMY WITHIN PAST WEEK FOR CHOLELITHIASIS

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I **certify** that (I) (this hospital) attended the deceased from 3-18-62, 19....., to 3-25-62, 19....., that (I) (we) last saw the deceased alive on 3-25-62, 19....., and that death occured at 2:15 AM, from the causes and on the date stated above.

22a. SIGNATURE: W H Ferguson MD M.D.

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): W.H Ferguson MD

22d. ADDRESS: 915 19th St NW DC

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: March 28-1962

23c. NAME OF CEMETERY OR CREMATORY: Watts Cemetery

23d. LOCATION (City, town or county): Kermore (State): Penna.

24. FUNERAL DIRECTOR'S SIGNATURE: J Arthur Watters

ADDRESS: 254 Farrell St N.C.

25a. REC'D BY REGISTRAR DATE MAR 28 '62

25b. REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03431

## CERTIFICATE OF DEATH

Reg. Dist. No. 03424

**1. PLACE OF DEATH**
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Wheaton
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 2502 Arcola Ave.

**2. USUAL RESIDENCE** (Where deceased lived. If institution: Residence before admission)
a. STATE: ...ryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Wheaton 37
d. STREET ADDRESS: 2502 Arcola Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

**3. NAME OF DECEASED** (Type or print): First CHARLIE Middle LOUISE Last HIGDON

**4. DATE OF DEATH**: Month March Day 30 Year 1962

**5. SEX**: Female

**6. COLOR OR RACE**: White

**7. MARRIED** ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

**8. DATE OF BIRTH**: Oct. 7, 1906

**9. AGE** (In years last birthday): 55 yrs.

IF UNDER 1 YEAR: Months ___ Days ___ IF UNDER 24 HRS.: Hours ___ Min. ___

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): Housewife

**10b. KIND OF BUSINESS OR INDUSTRY**:

**11. BIRTHPLACE** (State or foreign country): Tenn.

**12. CITIZEN OF WHAT COUNTRY?**: U.S.A.

**13. FATHER'S NAME**: George Nelson

**14. MOTHER'S MAIDEN NAME**: Louise Pice

**15. WAS DECEASED EVER IN U. S. ARMED FORCES?** (Yes, no, or unknown): (If yes, give war or dates of service):

**16. SOCIAL SECURITY NO.**:

**17. INFORMANT**: Mrs. Dorothy Anne Laney, 703 Fletcher Place — Address Rockville, Md.

**MEDICAL CERTIFICATION**

**18. CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PSEUDO MUCINOUS CARCINOMA OF OVARY — INTERVAL BETWEEN ONSET AND DEATH: 6 MOS

DUE TO (b)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): NONE

**19. WAS AUTOPSY PERFORMED?** YES ☐ NO ☒

**20a. ACCIDENT WAS UNDERLYING** ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

**20b. DESCRIBE HOW INJURY OCCURRED.** (Enter nature of injury in Part I or Part II of item 18.)

**20c. TIME OF INJURY** Month, Day, Year — Hour a. m. p. m. 19

**20d. INJURY OCCURRED** While at work ☐ Not while at work ☐

**20e. PLACE OF INJURY** (Home, farm, factory, street, office bldg., etc.)

**20f.** (City or town) (County) (State)

**21. I certify** that I attended the deceased from FEB 11, 1962 to MAR. 30, 1962 that I last saw the deceased alive on MAR 30, 1962, and that death occurred at 7:00 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: John H. Duchy M.D. — ADDRESS (Street, city or town, state): — DATE SIGNED: 3/30/62

PHYSICIAN'S NAME (Type): 7720 WISCONSIN AVE BETHESDA, MD.

**22a. BURIAL, CREMATION, REMOVAL** (Specify): BURIAL

**22b. DATE THEREOF**: 4-4-62

**22c. NAME OF CEMETERY OR CREMATORY**: HIGHLAND PARK

**22d. LOCATION** (City, town, or county) (State): MAYFEILD, KY

**23. FUNERAL DIRECTOR'S SIGNATURE**: Chevy Chase Funeral Home — ADDRESS: 5101 Wisc. Ave. N.W.

**24a. REC'D BY REGISTRAR** DATE APR 4 '62

**24b. REGISTRAR'S SIGNATURE**: Arthur S. Hanna

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03432 **CERTIFICATE OF DEATH** 03425

Item 16 Film 2241 Strip 5 ams

**1. PLACE OF DEATH**
a. COUNTY: Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 16: 52 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): The Clinical Center, Bethesda 14, Md.

MARYLAND

**2. USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
e. STATE: Maryland
b. COUNTY: Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hyattsville, 16
d. STREET ADDRESS: 4 07 - 70th Place, Woodlawn
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

M 50

**3. NAME OF DECEASED** (Type or print): First: William (No middle name) Middle: Last: Hite

**4. DATE OF DEATH**: Month: March Day: 16, Year: 19 62

**5. SEX**: Male
**6. COLOR OR RACE**: White
**7. MARRIED** ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐
**8. DATE OF BIRTH**: 10 September 1922
**9. AGE** (In years last birthday): 39 yrs. IF UNDER 1 YEAR: Months / Days / Hours / Min.

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): Central Office Repairman
**10. KIND OF BUSINESS OR INDUSTRY**: Telephone Company
**11. BIRTHPLACE** (County & State, or foreign country): Washington, D.C.
**12. CITIZEN OF WHAT COUNTRY?**: U.S.A.

**13. FATHER'S NAME**: Russell Hite
**14. MOTHER'S MAIDEN NAME**: Ruth Kuhnert

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unknown): Yes (If yes give war or dates of service): WW II
**16. SOCIAL SECURITY NO.**: 579-20-8[illegible]
**17. INFORMANT**: The Medical Record Address: The Clinical Center, Bethesda 14, Maryland

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**MEDICAL CERTIFICATION**

**18. CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypotension — INTERVAL BETWEEN ONSET AND DEATH: 15 hours

204.3

DUE TO (b) Bronchopneumonia and [redacted]tecemia — 6 days

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) Acute leukemia — 3 months

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

**19. WAS AUTOPSY PERFORMED?** YES ☒ NO ☐

2

**20a. ACCIDENT WAS UNDERLYING** ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)
**20b. DESCRIBE HOW INJURY OCCURED.** (Enter nature of injury in Part I or Part II of Item 18.)
**20c. TIME OF INJURY** Hour a.m. p.m. Month, Day, Year 19
**20d. INJURY OCCURRED** While at work ☐ Not While at work ☐
**20e. PLACE OF INJURY** (Home, farm, factory, street, office bldg., etc.)
**20f.** (City or town) (County) (State)

**21. I certify** that (I) (this hospital) attended the deceased from January 23, 1962 to March 16, 1962, that (I) (we) last saw the deceased alive on March 16, 19 62, and that death occured at 6:10 AM from the causes and on the date stated above.

**22a. SIGNATURE**: Robert H. Levin, M.D.
**22b. DATE SIGNED**: Mar 16, 1962
**22c. PHYSICIAN'S NAME** (Type): Robert H. Levin M.D.
M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
**22d. ADDRESS**: The Clinical Center, National Institutes of Health, Bethesda 14, Md.

**23a. BURIAL, CREMATION, REMOVAL** (Specify): Burial
**23b. DATE THEREOF**: 3-19-1962
**23c. NAME OF CEMETERY OR CREMATORY**: Arlington Natl
**23d. LOCATION** (City, town or county): Arlington, Va (State)

**24 FUNERAL DIRECTOR'S SIGNATURE**: Robert A. Mattingly
ADDRESS: 1317-11 St Wash. D.C.
**25a. REC'D BY REGISTRAR** DATE: MAR 20 '62
**25b. REGISTRAR'S SIGNATURE**: [illegible]

**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

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M

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/58

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03433

## CERTIFICATE OF DEATH

Reg. Dist. No. 03426

1 PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SILVER SPRING
c. LENGTH OF STAY IN 1b: 2 1/2 yrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: JOHNSONS NURSING HOME

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: PRINCE GEORGE
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): COLLEGE PARK
d. STREET ADDRESS: BERWYN ROAD
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First: JULIA Middle: Last: HOLLAN
4. DATE OF DEATH: Month: MARCH Day: 15 Year: 1962

5. SEX: F
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐
8. DATE OF BIRTH: FEB. 16, 1878
9. AGE (In years last birthday): 86 yrs
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): HUNGARY
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: Unknown
INFORMANT: Rest Home Records — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY
(a) Congestive heart failure — INTERVAL BETWEEN ONSET AND DEATH: 2 weeks
DUE TO
(b) Generalized arteriosclerosis
DUE TO
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
450.0

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year — Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June 15 1960, to March 15, 1962 that I last saw the deceased alive on March 15, 1962, and that death occurred at 8:45 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: A F Thibadeau M.D. — ADDRESS (Street, city or town, state): 10111 COLESVILLE RD — DATE SIGNED: 3/15/62

PHYSICIAN'S NAME (Type): A. F. THIBADEAU, M.D. — SILVER SPRING MD

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 3/17/62
22c. NAME OF CEMETERY OR CREMATORY: Ft Lincoln
22d. LOCATION (City, town, or county) (State): Colmar Manor, Md

23. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: F. Marsh Sons Hyattsville, Md
24a. REC'D BY REGISTRAR DATE MAR 19 '62
24b. REGISTRAR'S SIGNATURE: A. Thos S. Kraus

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03434 **CERTIFICATE OF DEATH** 03427

1. PLACE OF DEATH
a. COUNTY: Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): rural Silver Spring
c. LENGTH OF STAY IN 1b: MARYLAND
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): LeDeau

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: D. C.
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington - District of Columbia 47
d. STREET ADDRESS: 1900 F. Street, N. W., apt.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First SELDEN GRANT Middle HOPKINS Last
4. DATE OF DEATH: Month March Day 30 Year 1962
5. SEX: M
6. COLOR OR RACE: white
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: July 5, 1862
9. AGE (In years last birthday): 99 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): retired - Board of Appeals - Civil Rights / Civil Service Commission
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Castle Rock, Wis.
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Jacob Hopkins
14. MOTHER'S MAIDEN NAME: not known
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: none
17. INFORMANT: Philip S. Hopkins, son, 3900 16th St., N. W. Washington, D. C.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Inanition
DUE TO (b) Aging
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Chronic Heart Disease (Mild Failure Compensated)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (~~this hospital~~) attended the deceased from Feb 14, 1962 to Mar 30, 1962, that (I) (~~we~~) last saw the deceased alive on Mar 30, 1962, and that death occured at 4:00 P.M., from the causes and on the date stated above.

22a. SIGNATURE: Robert T. Thibadeau M.D.
22b. DATE SIGNED: Mar 30-62
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22c. PHYSICIAN'S NAME (Type): ROBERT T. THIBADEAU
22d. ADDRESS: 10609 Concord St. Kensington, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): burial
23b. DATE THEREOF: April 2, 1962
23c. NAME OF CEMETERY OR CREMATORY: National Memorial Park
23d. LOCATION (City town or county) (State): Fairfax County, Virginia

24. FUNERAL DIRECTOR'S SIGNATURE: J.E. Gray
ADDRESS: Ives Funeral Home, Inc. 2847 Wilson Blvd., Arlington, Va.
25a. REC'D BY REGISTRAR DATE APR 3 '62
25b. REGISTRAR'S SIGNATURE: Clifton J. Evans

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed in 24 hours after death. Page 4 should be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03435

## CERTIFICATE OF DEATH

03428

**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 1 should be retained by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: 10 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Washington San & Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Md.
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Derwood
d. STREET ADDRESS: Redland Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Paul; Middle: Edward; Last: Hettinger
4. DATE OF DEATH: Month: March; Day: 7; Year: 1962
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: ~~Ma~~ 8-4-22
9. AGE (In years last birthday): 39 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Field Mgr. Insp.
10b. KIND OF BUSINESS OR INDUSTRY: Elec.-Pub. Utility
11. BIRTHPLACE (County & State or foreign country): W. Va.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Wilbur Hettinger
14. MOTHER'S MAIDEN NAME: Florence Brady
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): yes WW 2
16. SOCIAL SECURITY NO.: 218-18-5368
17. INFORMANT: Address: Washington Sanitarium Hospital Records

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

MEDICAL CERTIFICATION

| | | Interval between onset and death |
|---|---|---|
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) | Brain stem compression | 4 days |
| DUE TO (b) | Suspected brain tumor | 3 weeks |
| DUE TO (c) | | |

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): left hemiparesis, cause unknown 6 years

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Month, Day, Year; Hour a.m. p.m.; 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 2/26, 1962 to 3/7, 1962 that (I) (we) last saw the deceased alive on 3/7, 1962 and that death occured at 9 P.M., from the causes and on the date stated above.

22a. SIGNATURE: John T. Lord M.D.
M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 3/7/62
22c. PHYS CIAN'S NAME (Type): John T. Lord M.D.
22d. ADDRESS: 1015 Spring St. Silver Spring Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 3-10-62
23c. NAME OF CEMETERY OR CREMATORY: Flower Hill
23d. LOCATION (City, town or county) (State): Redland, Maryland
24. FUNERAL DIRECTOR'S SIGNATURE: Francis H. Barber
ADDRESS: Laytonsville, Maryland
25a. REC'D BY REGISTRAR DATE: MAR 12 '62
25b. REGISTRAR'S SIGNATURE: [illegible]

VR A1S (4)
1SM 7/61

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FOR STATE HEALTH DEPT.

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any [illegible] is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9 60

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03436 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 03429

1. PLACE OF DEATH
a. COUNTY: Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: D.O.A.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Washington Sanitarium & Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
d. STREET ADDRESS: 804 Burlington Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: James Middle: Clifton Last: Housley
4. DATE OF DEATH: Month: 3 Day: 13 Year: 1962
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: March 10, 1910
9. AGE (In years last birthday): 52 yrs. IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Electrician
10b. KIND OF BUSINESS OR INDUSTRY: Appliance Store
11. BIRTHPLACE (State or foreign country): Tennessee
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Albert Junior Housley
14. MOTHER'S MAIDEN NAME: Estella Hill
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No (If yes give war or dates of service): None
16. SOCIAL SECURITY NO.: 300-07-3457
17. INFORMANT: John Henry Housley Address: 6609 Poplar St Takoma Park, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a) (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary occlusion
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):
INTERVAL BETWEEN ONSET AND DEATH: sudden
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I.a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21 I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from. Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Frank J. Broschart M.D.
EXAMINER'S NAME (Type): FRANK J. BROSCHART
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county)
DATE SIGNED: Mar 13-1962

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 3-16-62
22c. NAME OF CEMETERY OR CREMATORY: Fort Lincoln Cemetery
22d. LOCATION (City, town, or country) (State): Prince George's Co, Maryland

23. FUNERAL DIRECTOR: Raymond A. Ziska ADDRESS: 8434 Georgia Ave
Warner E. Pumphrey, Inc., Silver Spring, Maryland
24a. REC'D BY REGISTRAR DATE: MAR 15 '62
24b. REGISTRAR'S SIGNATURE: Carlton L. Krause

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FOR STATE HEALTH DEPT.

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03437

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03430

1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda
c. LENGTH OF STAY IN 1b 20 yrs
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 6105 Wynnwood Rd

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Md
b. COUNTY Monty
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda
d. STREET ADDRESS 6105 Wynnwood Rd
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Daisy Middle Frances Last Huddleson

4. DATE OF DEATH Month Mar Day 25 Year 1962

5. SEX Female
6. COLOR OR RACE White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH Aug 13 1897
9. AGE (In years last birthday) 64 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk - U.S. Treasury
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Va
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Charlie F. Cornell
14. MOTHER'S MAIDEN NAME Annie Belle Reuter

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) No (If yes give war or dates of service)
16. SOCIAL SECURITY NO. 577-60-1390
17. INFORMANT Harvey Huddleson (Husband) Address Route 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary occlusion
DUE TO
(b)
DUE TO
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH sudden

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I.(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE Frank J. Broschart M.D.
EXAMINER'S NAME (Type) FRANK J. BROSCHART
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county)
DATE SIGNED 3-25-62

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 3/29/62
22c. NAME OF CEMETERY OR CREMATORY Arlington Nat. Cem.
22d. LOCATION (City, town, or country) Arlington, Virginia (State)

23. FUNERAL DIRECTOR ADDRESS Robert A. Pumphrey, Bethesda, Maryland
24a. REC'D BY REGISTRAR DATE MAR 27 '62
24b. REGISTRAR'S SIGNATURE [illegible]

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any [illegible] is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03438

## CERTIFICATE OF DEATH

03431

**1. PLACE OF DEATH**
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 3 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Suburban

**2. USUAL RESIDENCE** (Where deceased lived, if institution, Residence before admission)
a. STATE: Md.
b. COUNTY: Mont. Co.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
d. STREET ADDRESS: 130 — Woodridge Ave.
a. IS RESIDENCE ON A FARM? YES ☐ NO ☒

**3. NAME OF DECEASED** (Type or print): First: Willard; Middle: Phillips; Last: Hummewell

**4. DATE OF DEATH**: Month: March; Day: 14; Year: 1962

**5. SEX**: Male

**6. COLOR OR RACE**: White

**7. MARRIED** ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

**8. DATE OF BIRTH**: 1/26/03

**9. AGE** (In years last birthday): 59 yrs.

IF UNDER 1 YEAR: Months: ; Days: ; IF UNDER 24 HRS.: Hours: ; Min.:

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): Clerical

**10b. KIND OF BUSINESS OR INDUSTRY**: Banking

**11. BIRTHPLACE** (County & State, or foreign country): Lynn Mass.

**12. CITIZEN OF WHAT COUNTRY?**: U.S.A.

**13. FATHER'S NAME**: Wm. Hummewell

**14. MOTHER'S MAIDEN NAME**: Abbie Phillips.

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unknown): No

**16. SOCIAL SECURITY NO** (If yes give war or dates of service): No 030-03-7777

**17. INFORMANT**: Hazel T. Hummewell — Address: Same

**18. CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a): Uremia + Congestive Heart failure — INTERVAL BETWEEN ONSET AND DEATH: 3 weeks.

DUE TO (b): Acute cor pulmonale — 3 weeks

DUE TO (c): Pulmonary emphysema. — + 20 years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c): Carcinoma of bladder + prostate.

**19. WAS AUTOPSY PERFORMED?** YES ☐ NO ☒

**2Da. ACCIDENT WAS UNDERLYING** ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

**2Db. DESCRIBE HOW INJURY OCCURED.** (Enter nature of injury in Part I or Part II of Item 18.)

**2Dc. TIME OF INJURY** Hour a.m. p.m. Month, Day, Year 19

**2Dd. INJURY OCCURRED** While at work ☐ Not While at work ☐

**2De. PLACE OF INJURY** (Home, farm, factory, street, office bldg., etc.)

**2Df.** (City or town) (County) (State)

**21. I certify** that (I) (this hospital) attended the deceased from March 11, 1962 to March 14, 1962, that (I) (we) last saw the deceased alive on March 14, 1962, and that death occured at 6:30 P.M. from the causes and on the date stated above

**22a. SIGNATURE**: [signature]

M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

**22b. DATE SIGNED**: March 15, 1962

**22c. PHYSICIAN'S NAME** (Type): BLAINE H. EIG

**22d. ADDRESS**: 8641 Colesville Rd Silver Spring, Md.

**23a. BURIAL, CREMATION, REMOVAL** (Specify): Burial

**23b. DATE THEREOF**: 2-17-62

**23c. NAME OF CEMETERY OR CREMATORY**: Forrest Hill Cemetery

**23d. LOCATION** (City, town or county) (State): Fitchburg, Worcester Co, Mass.

**24 FUNERAL DIRECTOR'S SIGNATURE**: Raymond A. Gibbs — ADDRESS: 8434 Georgia Ave.

Warner E. Pumphrey, Inc., Silver Spring, Maryland

**25a. REC'D BY REGISTRAR** DATE: MAR 19 '62

**25b. REGISTRAR'S SIGNATURE**: [signature]

MEDICAL CERTIFICATION

**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03439

## CERTIFICATE OF DEATH

03432

**1. PLACE OF DEATH**
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: 3 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Washington San + Hosp.

**2. USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 16 Silver Spring
d. STREET ADDRESS: 1612 Yeeley Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: David — Middle: Maxwell — Last: Hunt
4. DATE OF DEATH: Month: March — Day: 30 — Year: 1962
5. SEX: male
6. COLOR OR RACE: white
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 5-17-13
9. AGE (In years last birthday): 48 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): auto mechanic
10b. KIND OF BUSINESS OR INDUSTRY: auto - garage
11. BIRTHPLACE (County & State, or foreign country): Newfoundland
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME: John Hunt
14. MOTHER'S MAIDEN NAME: Elsie (does not remember)
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): yes — (If yes give war or dates of service): WW 2 - army
16. SOCIAL SECURITY NO.
17. INFORMANT: chart - hospital records. Address: O. Lindsay.

**MEDICAL CERTIFICATION**

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Congestive Heart Failure — INTERVAL BETWEEN ONSET AND DEATH: One Hour
DUE TO (b) Bronchial Pneumonia — Several Days
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)
4 91X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Bronchial Asthma Chronic Emphysema

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21 **I certify** that (I) (this hospital) attended the deceased from March 28, 1962 to March 30, 1962 that (I) (we) last saw the deceased alive on March 30, 1962 and that death occured at 6:00 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Stuart D. Nelson M.D.
ATTENDING PHYS. ☒ MED DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 3-30-62
22c. PHYSICIAN'S NAME (Type): STUART D. NELSON
22d. ADDRESS: WASH. SAN + HOSP.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: April 3, 1962
23c. NAME OF CEMETERY OR CREMATORY: Arlington Natl
23d. LOCATION (City, town or county) (State): Arlington VA

24 FUNERAL DIRECTOR'S SIGNATURE: W W Patterson
ADDRESS: 3603 14th St NW DC 10
25a. REC'D BY REGISTRAR: DATE APR 2 '62
25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
15M 7/61

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# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03440 **CERTIFICATE OF DEATH** 03433

**1. PLACE OF DEATH**
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 1 hrs. 20 mins.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Suburban

**2. USUAL RESIDENCE** (Where deceased lived, if institution: Res dence before admiss on)
a. STATE: Md.
b. COUNTY: Mont. Co.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Spencerville
d. STREET ADDRESS: Thompson Road 14
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

**3. NAME OF DECEASED** (Type or print): First Ida Middle Mae Last Jackson

**4. DATE OF DEATH**: Month March Day 26 Year 1962

**5. SEX**: Female

**6. COLOR OR RACE**: Colored

**7. MARRIED** ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

**8. DATE OF BIRTH**: Jan 30/21

**9. AGE** (In years last birthday): 41 yrs.
IF UNDER 1 YEAR: Months | Days | IF UNDER 24 HRS.: Hours | Min.

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): Domestic

**10b. KIND OF BUSINESS OR INDUSTRY**: Private

**11. BIRTHPLACE** (County & State, or foreign country): Maryland

**12. CITIZEN OF WHAT COUNTRY?**: U.S.A.

**13. FATHER'S NAME**: Clifton George Thomas

**14. MOTHER'S MAIDEN NAME**: Mary ?

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unkown): No

**16. SOCIAL SECURITY NO**: No

**17. INFORMANT**: 217-32-7344 Milton Jackson Jr. Address: Same as above.

**MEDICAL CERTIFICATION**

**18. CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Heart Failure — INTERVAL BETWEEN ONSET AND DEATH: 24 hours

DUE TO (b) Chronic Pulmonary Emphysema. — 5 years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

**19. WAS AUTOPSY PERFORMED?** YES ☒ NO ☐

**20a. ACCIDENT WAS UNDERLYING** ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

**20b. DESCRIBE HOW INJURY OCCURED** (Enter nature of injury in Part I or Part II of Item 18.)

**20c. TIME OF INJURY** Hour a.m. p.m. Month, Day, Year 19

**20d. INJURY OCCURRED** While at work ☐ Not While at work ☐

**20e. PLACE OF INJURY** (Home, farm, factory, street, office bldg., etc.)

**20f.** (City or town) (County) (State)

**21. I certify** that (I) (this hospital) attended the deceased from 3/26/62, 19 to 3/26, 1962 that (I) (we) last saw the deceased alive on 3/26 19 62, and that death occured at 7 P.M. from the causes and on the date stated above.

**22a. SIGNATURE**: John E. Everett M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

**22b. DATE SIGNED**: 3/26/62

**22c. PHYSICIAN'S NAME** (Type): JOHN E. EVERETT

**22d. ADDRESS**: 9400 Conn Ave Kensington

**23a. BURIAL, CREMATION, REMOVAL** (Specify): Burial

**23b. DATE THEREOF**: 3/30/62

**23c. NAME OF CEMETERY OR CREMATORY**: Round Oak.,

**23d. LOCATION** (City, town or county): Spencerville, Md. (State)

**24. FUNERAL DIRECTOR'S SIGNATURE**: Robert L. Snowden

ADDRESS: Rockville, Md.

**25a. REC'D BY REGISTRAR** DATE MAR 30 '62

**25b. REGISTRAR'S SIGNATURE**: Arthur S. Kraus

**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 1 should be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

Items 20, 21 Film 309 3-21 03434

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03434

FOR STATE HEALTH DEPT. 1

1. PLACE OF DEATH
a. COUNTY: Montgomery
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: DOA
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Suburban Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Mont.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
d. STREET ADDRESS: 15740 Goodhope Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Louis; Middle: Nathanial; Last: Jackson
4. DATE OF DEATH: Month: March; Day: 2; Year: 1962
5. SEX: Male
6. COLOR OR RACE: Colored
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒
8. DATE OF BIRTH: 1/23/1900
9. AGE (In years last birthday): 62 yrs. IF UNDER 1 YEAR: Months / Days; IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Louis B. Jackson
14. MOTHER'S MAIDEN NAME: Laura Johnson
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Hester H. Hackley, Address: item 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Exposure to cold
932.0
DUE TO
(b): Acute alcoholism
DUE TO
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Found dead in an unheated tool shed at home.

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from Natural causes ☐ Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Frank J. Broschart M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 3-2-62
EXAMINER'S NAME (Type): Frank J. Broschart
Address (Street, city, town, or county)

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 3/4/62
22c. NAME OF CEMETERY OR CREMATORY: Sandy Spring,
22d. LOCATION (City, town, or county) (State): Sandy Spring, Md.

23. FUNERAL DIRECTOR: Robert L. Snowden
ADDRESS: Rockville, Md.

24a. REC'D BY REGISTRAR: DATE MAR 7 '62
24b. REGISTRAR'S SIGNATURE

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any [illegible] is necessary, please execute [illegible] certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. ASME SM 9 60

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03442

## CERTIFICATE OF DEATH

03435
Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Montgomery MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
c. LENGTH OF STAY IN 1b: 6 1/2 yrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: —

2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
d. STREET ADDRESS: 3719 Kanson St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First Chester Middle Clayton Last James

4. DATE OF DEATH: Month March Day 23 Year 1962

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: May 23, 1922
9. AGE (In years last birthday): 39 yrs.
IF UNDER 1 YEAR / IF UNDER 24 HRS.: Months | Days | Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired): Plumber
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Washington D.C.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Charles E. James
14. MOTHER'S MAIDEN NAME: Essa E. Thompson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): W W II
16. SOCIAL SECURITY NO.: 577-22-8374
17. INFORMANT: Mrs. Charles E. James Address: Same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: Sudden
DUE TO
(b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Oct 29, 1961, to March 23 1962 that I last saw the deceased alive on March 23, 1962, and that death occurred at 6:45 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Philip E. Jones M.D. ADDRESS (Street, city or town, state): 918 ~~Silver Spring~~ Ellsworth Drive DATE SIGNED: 3/23/62

PHYSICIAN'S NAME (Type): Phillip E. Jones Silver Spring Md

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Mar 26-62
22c. NAME OF CEMETERY OR CREMATORY: Cedar Hill
22d. LOCATION (City, town, or county) (State): Suitland Md

23. FUNERAL DIRECTOR'S SIGNATURE: Simmons Bros. Funeral Home ADDRESS: 1661 - Good Hope Rd SE Wash DC
24a. REC'D BY REGISTRAR DATE MAR 27 '62
24b. REGISTRAR'S SIGNATURE: Arthur S. Marks

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be returned to the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03443 **CERTIFICATE OF DEATH** 03436

**1. PLACE OF DEATH**
a. COUNTY: MONTGOMERY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: MARYLAND
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 4949 Battery Lane

**2. USUAL RESIDENCE** (Where deceased lived, If Institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: MONTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
d. STREET ADDRESS: 4949 Battery Lane
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

**3. NAME OF DECEASED** (Type or print): First GEORGE Middle WALDEMAR Last JENSEN

**4. DATE OF DEATH** Month: MARCH Day: 20 Year: 1962

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Oct. 6, 1886
9. AGE (In years last birthday): 75 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Shipping - Steam Ship - Retired
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State or foreign country): Copenhagen, Denmark
12. CITIZEN OF WHAT COUNTRY? U.S. Naturalized.

13. FATHER'S NAME: Waldemar Jensen
14. MOTHER'S MAIDEN NAME: Hansine Jensen

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)
16. SOCIAL SECURITY NO
17. INFORMANT: Wife Johanna Jensen Address: Same as Item 2.

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) MYOCARDIAL FAILURE WITH INFARCTION — INTERVAL BETWEEN ONSET AND DEATH: 2 HRS.
DUE TO (b) GENERALIZED ARTERIOSCLEROSIS & ARTERIOSCLEROTIC — 2 YRS.
DUE TO (c) HEART DISEASE QUADRIPLEGIC PAST 4 MONTHS, RESULT CVA
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): CVA WITH CORD INJURY - FOUR MONTHS AGO

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from July 1950 to MAR 20, 1962 that (I) (we) last saw the deceased alive on MAR 20 1962, and that death occured at 12:15 AM, from the causes and on the date stated above.

22a. SIGNATURE: William B. Walsh M.D. M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: Mar 20 1962
22c. PHYSICIAN'S NAME (Type): WILLIAM B. WALSH M.D.
22d. ADDRESS: 1835 EYE ST. N.W. - WASH. D.C.

23a. BURIAL, CREMATION, REMOVAL (Specify): Cremation
23b. DATE THEREOF: 3/23/62
23c. NAME OF CEMETERY OR CREMATORY: Ft. Lincoln Crematory
23d. LOCATION (City, town or county) (State): Prince George Co., Md.

24. FUNERAL DIRECTOR'S SIGNATURE: ROBERT A. PUMPHREY
ADDRESS: Bethesda, Md.
25a. REC'D BY REGISTRAR DATE MAR 23 '62
25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed in 24 hours after death. Page 4 should be retained by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

03444 **CERTIFICATE OF DEATH** 03437

**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed in 24 hours after death. Page 4 should be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1. PLACE OF DEATH
a. COUNTY: Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
c. LENGTH OF STAY IN this place: 3 months
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Marilea Nursing Home

2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 29 Silver Spring
d. STREET ADDRESS: 10,400 Hayes Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Thomas; Middle H.; Last Johnson
4. DATE OF DEATH: Month March; Day 6; Year 1962
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Feb. 10, 1875
9. AGE (In years last birthday): 87 yrs. IF UNDER 1 YEAR: Months, Days. IF UNDER 24 HRS.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Egg salesman
10b. KIND OF BUSINESS OR INDUSTRY: Own business
11. BIRTHPLACE (County & State or foreign country): Alabama
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Unknown
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No None
16. SOCIAL SECURITY NO.: 579-28-1657
17. INFORMANT: Mrs. Elmer W. Michels
Address: 10,400 Hayes Ave, S.S., Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Bronchopneumonia
DUE TO (b)
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: 2 months

PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from December, 1961, to March 6, 1962, that (I) (we) last saw the deceased alive on March 5, 1962, and that death occured at 11:55 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Bennet A. Porter Jr. M.D.
22b. DATE SIGNED: March 7, 1962
22c. PHYSICIAN'S NAME (Type): Bennet A. Porter, Jr., MD
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22d. ADDRESS: 9301 Colesville Rd., Silver Spring, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 3-9-62
23c. NAME OF CEMETERY OR CREMATORY: Glenwood Cemetery
23d. LOCATION (City, town or county) (State): Washington, D.C.

24 FUNERAL DIRECTOR'S SIGNATURE: Raymond A. Zeller ADDRESS: 8434 Georgia Ave.
Warner E. Pumphrey, Inc. Silver Spring, Md.

25a. REC'D BY REGISTRAR: DATE MAR 9 '62
25b. REGISTRAR'S SIGNATURE: Arthur L. Kurtz

1

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03445 **CERTIFICATE OF DEATH** 03438

**1. PLACE OF DEATH**
a. COUNTY: Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): TAKOMA PARK
c. LENGTH OF STAY IN 1b: D.O.A.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Wash San + Hosp

MARYLAND

**2. USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
a. STATE: VIRGINIA
b. COUNTY: Essex
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Tappahannock
d. STREET ADDRESS: Box 56
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

**3. NAME OF DECEASED** (Type or print): First: EVA ~~Lorraine~~ Lorren; Middle: ; Last: Johnston

**4. DATE OF DEATH**: Month 3 Day 6 Year 1962

5. SEX: ~~M~~ female
6. COLOR OR RACE: W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 9-23-79
9. AGE (In years last birthday): 82 yrs. IF UNDER 1 YEAR: Months ; Days ; IF UNDER 24 HRS.: Hours ; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Own home
11. BIRTHPLACE (County & State, or foreign country): West VA
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: FRANKLIN BECK
14. MOTHER'S MAIDEN NAME: ELIZABETH STUMP

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No (If yes give war or dates of service): None
16. SOCIAL SECURITY NO.: None
17. INFORMANT: MR. O M. JONES Address: 806 HERON Dr S Md

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 10 min.

4 hr

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b) Senile Arteriosclerosis — 10 yrs.
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Diabetes Mellitus

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (~~this hospital~~) attended the deceased from Feb 1, 1962 to Mar 6, 1962, that (I) (we) last saw the deceased alive on Mar 5, 1962, and that death occured at 6:45 A.M., from the causes and on the date stated above.

22a. SIGNATURE: H. B. Queen M.D.
22b. DATE SIGNED: 7 Mar 1962
ATTENDING PHYS. ☒ MED DIRECTOR ☐ STAFF PHYS. ☐
22c. PHYSICIAN'S NAME (Type): H. B. QUEEN
22d. ADDRESS: 7112 Willow Ave Takoma Park Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 3-9-62
23c. NAME OF CEMETERY OR CREMATORY: Oak Hill Cemetery
23d. LOCATION (City, town or county) (State): Fredericksburg Spottsylvania Co ~~Tappahannock Essex Co~~, Virginia

24. FUNERAL DIRECTOR'S SIGNATURE: Raymond A. Zisk ADDRESS: 8434 Georgia Ave
Warner E. Pumphrey, Inc. Silver Spring, Maryland

25a. REC'D BY REGISTRAR DATE MAR 9 '62
25b. REGISTRAR'S SIGNATURE: Arthur J. Hanes

**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7 61

**MARYLAND STATE DEPARTMENT OF HEALTH**

**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

# CERTIFICATE OF DEATH

03446 03439

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BETHESDA
c. LENGTH OF STAY IN this place: 23 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): SUBURAN HOSPITAL

MARYLAND

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Md
b. COUNTY: MONTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 26 BETHESDA (WESTHAVEN)
d. STREET ADDRESS: 5103 BROOKVIEW DRIVE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Mollie; Middle: C.; Last: JUMP
4. DATE OF DEATH: Month: MAR; Day: 12; Year: 1962
5. SEX: F
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐
8. DATE OF BIRTH: 19 JUNE 1864
9. AGE (In years last birthday): 97 yrs. IF UNDER 1 YEAR: Months / Days; IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): CLERICAL
10b. KIND OF BUSINESS OR INDUSTRY: U.S. GOVR
11. BIRTHPLACE (County & State, or foreign country): BALTIMORE, Md
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: SAMUEL ADAMS CLICKNER
14. MOTHER'S MAIDEN NAME: JANE REED
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: NONE
17. INFORMANT: MR K. FOOTE Address: ABOVE

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): HEART FAILURE — INTERVAL BETWEEN ONSET AND DEATH: 12 MAR 62
DUE TO (b): GENERAL DETERIORATION
DUE TO (c): HYPOSTATIC PNEUMONIA — 14 FEB 62
~~FRACTURE L I HIP~~

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: FRACTURE LT HIP

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.): PT FELL AT HOME
20c. TIME OF INJURY: Hour a.m. p.m. NOON; Month, Day, Year: 12 FEB 14 62 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): HOME
20f. (City or town): WEST HAVEN (County): MONT. (State): Md

21. I certify that (I) (this hospital) attended the deceased from 15 FEB., 1962 to 12 MAR., 1962, that (I) ~~(we)~~ last saw the deceased alive on 9 MAR 1962 and that death occured at 3 A.M. from the causes and on the date stated above.

22a. SIGNATURE: Marvin M Gibson M.D.
ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 12 Mar 62
22c. PHYSICIAN'S NAME (Type): MARVIN M GIBSON
22d. ADDRESS: 1835 EYE ST NW WASH D.C.

23a. BURIAL, CREMATION, REMOVAL (Specify): burial
23b. DATE THEREOF: 3/14/62
23c. NAME OF CEMETERY OR CREMATORY: Loudon Park Cemetery
23d. LOCATION (City, town or county): Baltimore, Md. (State):

24. FUNERAL DIRECTOR'S SIGNATURE: The S.H. Hines Company
ADDRESS: 2901 14th St. N.W. ~~Washington 9, D.C.~~
25a. REC'D BY REGISTRAR (DATE): MAR 14 '62
25b. REGISTRAR'S SIGNATURE: [illegible]

**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Coroner notified and approved

VR A15 (4)
15M 7/61

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03447 **CERTIFICATE OF DEATH** 03440

**1. PLACE OF DEATH**
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda (Rural)
c. LENGTH OF STAY IN this place: 14 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): U. S. Naval Hospital

**2. USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
a. STATE: Virginia
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Alexandria
d. STREET ADDRESS: 941 N. VanDoren
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

**3. NAME OF DECEASED** (Type or print): First: Lucille Middle: Marie Last: Juskie

**4. DATE OF DEATH**: Month: March Day: 20, Year: 1962

**5. SEX**: Female

**6. COLOR OR RACE**: Caucasian

**7. MARRIED** ☐ **NEVER MARRIED** ☒ **WIDOWED** ☐ **DIVORCED** ☐

**8. DATE OF BIRTH**: May 24, 1926

**9. AGE** (In years last birthday): 36 yrs. — IF UNDER 1 YEAR: Months: Days: — IF UNDER 24 HRS.: Hours: Min.:

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): Housewife

**10b. KIND OF BUSINESS OR INDUSTRY**:

**11. BIRTHPLACE** (County & State, or foreign country): Lake Charles, La.

**12. CITIZEN OF WHAT COUNTRY?**: USA

**13. FATHER'S NAME**: H. L. PEARCE

**14. MOTHER'S MAIDEN NAME**: Laura Barrett

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unkown): No

**16. SOCIAL SECURITY NO.** (If yes give war or dates of service): - - - - - - 437 24 5927

**17. INFORMANT** Address: HUSBAND: Ben Juskie, Same as #2

**18. CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinoma of Breast
DUE TO (b) Brain Metastasis
DUE TO (c)

170X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

**19. WAS AUTOPSY PERFORMED?** YES ☒ NO ☐

**20a** ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

**20b.** DESCRIBE HOW INJURY OCCURED (Enter nature of injury in Part I or Part II of item 18.)

**20c.** TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

**20d.** INJURY OCCURRED While at work ☐ Not While at work ☐

**20e.** PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

**20f.** (City or town) (County) (State)

**21. I certify** that I (this hospital) attended the deceased from March 6, 1962, to March 20, 1962, that I (we) last saw the deceased alive on March 20, 1962, and that death occured 1:00PM from the causes and on the date stated above.

**22a** SIGNATURE: William C. Monell M.D.

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

**22b** DATE SIGNED: March 20, 1962

**22c.** PHYSICIAN'S NAME (Type): WILLIAM C. MONELL LT MC USN

**22d.** ADDRESS: U. S. Naval Hospital, Bethesda, Md.

**23a.** BURIAL, CREMATION, REMOVAL (Specify): Burial

**23b** DATE THEREOF: 3-23-62

**23c.** NAME OF CEMETERY OR CREMATORY: Arlington National

**23d.** LOCATION (City, town or county) (State): Arlington, Virginia

**24** FUNERAL DIRECTOR'S SIGNATURE: M. R. Quick ADDRESS: Everly-Wheatley Funeral Home, Alexandria, Va.

**25a.** REC'D BY REGISTRAR DATE: MAR 23 '62

**25b.** REGISTRAR'S SIGNATURE: Arthur L. Krause

**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 is retained by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
1SM 7/61

# MARYLAND STATE DEPARTMENT OF HEALTH

**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

03448

## CERTIFICATE OF DEATH

03441

**1. PLACE OF DEATH**
a. COUNTY: Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN MARYLAND: 3 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): The Clinical Center, Bethesda 14, Md.

**2. USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Kensington,
d. STREET ADDRESS: 10604 Wheatley Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Herbert; Middle: (No middle name); Last: Kahler

4. DATE OF DEATH: Month: March; Day: 29; Year: 19 62

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 20 December 1896
9. AGE (In years last birthday): 65 yrs.
IF UNDER 1 YEAR: Months | Days
IF UNDER 24 HRS.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Bio. Physicist & P.H.D.
10b. KIND OF BUSINESS OR INDUSTRY: Federal Government
11. BIRTHPLACE (County & State, or foreign country): Oregon
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Orange Kahler
14. MOTHER'S MAIDEN NAME: Lena Dunlap

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): NO
(If yes give war or dates of service):
16. SOCIAL SECURITY NO.: None
17. INFORMANT: The Medical Record, Address: The Clinical Center, Bethesda 14, Maryland

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Chronic Lymphatic Leukemia — INTERVAL BETWEEN ONSET AND DEATH: 9 years
DUE TO (b) Septicemia — 6 hours
DUE TO (c) Possible viral hepatitis — 2 weeks

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

204-3

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from March 26, 1962 to March 29, 1962, that (I) (we) last saw the deceased alive on March 29, 1962, and that death occured at 10:20 A.M., from the causes and on the date stated above.

22a. SIGNATURE: Martin J. Cline, M.D.
22b. DATE SIGNED: 3/29/62
22c. PHYSICIAN'S NAME (Type): Martin J. Cline, MD.
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22d. ADDRESS: The Clinical Center, National Institutes of Health, Bethesda 14, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 3/31/62
23c. NAME OF CEMETERY OR CREMATORY: Rockville Cemetery
23d. LOCATION (City, town or county) (State): Rockville, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: Robert A. Pumphrey, Bethesda, Maryland

25a. REC'D BY REGISTRAR: DATE APR 2 '62
25b. REGISTRAR'S SIGNATURE: Arthur S. Kruse

**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03449 **CERTIFICATE OF DEATH** 03442

1. PLACE OF DEATH
a. COUNTY: Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN MARYLAND: 16 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Suburban

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Md
b. COUNTY: Mont. Co.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cabin John
d. STREET ADDRESS: 6516 - 76th. Pl.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: George Middle: E. Last: Kane

4. DATE OF DEATH: Month: March Day: 9 Year: 1962

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 6/16/94
9. AGE (Last birthday) years: 67 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10b. KIND OF BUSINESS OR INDUSTRY: U
11. BIRTHPLACE (County & State, or foreign country): D.C.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: George Kane
14. MOTHER'S MAIDEN NAME: Annie Behrens

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
(If yes give war or dates of service): No
16. SOCIAL SECURITY NO.: 578-20-5261
17. INFORMANT: Albert Kearney Address: 4414 - 35th St. N.W. Wash. D.C.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute generalized peritonitis
DUE TO (b): Ulcer, duodenum
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 2/24, 1962 to 3/9, 1962, that (I) (we) last saw the deceased alive on 3/9 1962, and that death occured at 5 PM, from the causes and on the date stated above.

22a. SIGNATURE: W. Joyce M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 3/10/62
22c. PHYSICIAN'S NAME (Type): W. F. JOYCE
22d. ADDRESS: 5106 MAPLE RIDGE RD. BETHESDA, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 3-12-62
23c. NAME OF CEMETERY OR CREMATORY: Mt Olivet Cemetery
23d. LOCATION (City, town or county) (State): Washington, D.C.

24. FUNERAL DIRECTOR'S SIGNATURE: Francis J. Collins by A.R.
ADDRESS: 3821 14th St. Wash. D.C.
25a. RECD BY REGISTRAR DATE: MAR 12 '62
25b. REGISTRAR'S SIGNATURE: Albert S. Krauss

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03450

## CERTIFICATE OF DEATH

Reg. Dist. No. 03443

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BETHESDA
c. LENGTH OF STAY IN 1b: 13 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: SUBURBAN HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE: D.C. ~~MARYLAND~~ b. COUNTY: ~~MONTGOMERY~~
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): WASHINGTON, D.C. 47X13
d. STREET ADDRESS: 1416 Holly St NW, WASH.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First BLANCHE Middle S. Last KAUFFMAN
4. DATE OF DEATH: Month 3 Day 16 Year 1962
5. SEX: F
6. COLOR OR RACE: W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 6-23-89
9. AGE (In years last birthday): 72 yrs
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE
10b. KIND OF BUSINESS OR INDUSTRY: Own home
11. BIRTHPLACE (State or foreign country): Pa
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: John H. Summerville
14. MOTHER'S MAIDEN NAME: Margaret ~~Hinerman~~ McCaskey
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No (If yes, give war or dates of service): None
16. SOCIAL SECURITY NO: None
17. INFORMANT: Harvey E. Kauffman — Address: Same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSE BY:
(a) IMMEDIATE CAUSE: MYOCARDIAL INFARCTION — INTERVAL BETWEEN ONSET AND DEATH: 2 wks.
4-20-0
DUE TO
(b) ARTHRIOSCLEROTIC HEART DISEASE — 7 yrs.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year — Hour a. m. p. m. — 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 3-10, 1962, to 3-16, 1962, that I last saw the deceased alive on 3-16, 1962, and that death occurred at 8:30 A.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Richard H. Pollen M.D.
ADDRESS (Street, city or town, state): 10511 Summitt Avenue
DATE SIGNED: 3-16-62
PHYSICIAN'S NAME (Type): Richard Henry Pollen, M.D. Kensington, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 3-20-62
22c. NAME OF CEMETERY OR CREMATORY: Arlington National Cemetery
22d. LOCATION (City, town, or county) (State): Arlington, Virginia

23. FUNERAL DIRECTOR'S SIGNATURE: Raymond Gisler
ADDRESS: 8434 Georgia Ave
Warner E. Pumphrey, Inc. Silver Spring, Maryland
24a. REC'D BY REGISTRAR DATE MAR 20 '62
24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

15

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03451

## CERTIFICATE OF DEATH

03444

M

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 9 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Suburban

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: D.C.
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington
d. STREET ADDRESS: 3735 Jocelyn ST
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Thomas; Middle: Spriggs; Last: Kelley

4. DATE OF DEATH: Month: March; Day: 25; Year: 1962

5. SEX: M

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 1-22-81

9. AGE (In years last birthday): 81 yrs. IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired

10b. KIND OF BUSINESS OR INDUSTRY: Farmer

11. BIRTHPLACE (County & State, or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: James Kelley IV

14. MOTHER'S MAIDEN NAME: Felicia Elizabeth Spriggs

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No

(If yes give war or dates of service): - -

16. SOCIAL SECURITY NO.: - - -

17. INFORMANT: Address: Mrs. Enid Anthony - Sister

I

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 9 days.
DUE TO (b) Cancer Prostate c Metastises — 4 years.
DUE TO (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): None

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.): No

20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21 I certify that (I) (this hospital) attended the deceased from 1958, 19..., to 3-25, 19..., 1962 that (I) (we) last saw the deceased alive on 3-25 1962, and that death occured at ...M, from the causes and on the date stated above.

22a. SIGNATURE: Curtis S. Blumenthal M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type)

22d. ADDRESS: 5315 CONN. AVE. WASH. D.C.

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal

23b. DATE THEREOF: 3-26-1962

23c. NAME OF CEMETERY OR CREMATORY: Rehoboth Cemetery

23d. LOCATION (City, town or county) (State): Rehoboth, Va.

24 FUNERAL DIRECTOR'S SIGNATURE: Geo. Hamilton Funeral Dir.

ADDRESS: 1756 Pa Ave NW Washington 6, DC

25a. REC'D BY REGISTRAR DATE: MAR 27 '62

25b. REGISTRAR'S SIGNATURE: Arthur S. Fiano

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 7/61

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03452

## CERTIFICATE OF DEATH

03445

**1. PLACE OF DEATH**
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: 13 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Washington San. & Hosp.

**2. USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
d. STREET ADDRESS: 621 Hollywood Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Harold — Middle: Leon — Last: Kelly
4. DATE OF DEATH: Month: March — Day: 26 — Year: 1962
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 1/11/93
9. AGE (In years last birthday): 69 yrs. — IF UNDER 1 YEAR: Months Days — IF UNDER 24 HRS: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Fed. Employee
10b. KIND OF BUSINESS OR INDUSTRY: U.S. Government
11. BIRTHPLACE (County & State, or foreign country): Michigan
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Charles W. Kelly
14. MOTHER'S MAIDEN NAME: Julia Lee
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes give war or dates of service): None
16. SOCIAL SECURITY NO: 217-34-1593
17. INFORMANT: Wash. San. & Hosp — Address: Carroll Ave, Takoma Park, Md.

**MEDICAL CERTIFICATION**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinomatosis, generalized {PRIMARY IN TAIL OF PANCREAS — INTERVAL BETWEEN ONSET AND DEATH: 6 months +
DUE TO (b)
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Lobar pneumonia, with hydrothorax
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from ..... 1950, to Mar. 26, 1962, that (I) (we) last saw the deceased alive on Mar. 26, 1962, and that death occured at 9:30 A.M., from the causes and on the date stated above.

22a. SIGNATURE: John N. Andrews — M.D. — ATTENDING PHYS. ☒ MED DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 3-27-62
22c. PHYSICIAN'S NAME (Type): John N. Andrews
22d. ADDRESS: 9601 Colesville Rd Silver Spring Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 3-29-62
23c. NAME OF CEMETERY OR CREMATORY: George Washington Cemetery
23d. LOCATION (City, town or county) (State): Hyattsville Pr. George's Maryland

24. FUNERAL DIRECTOR'S SIGNATURE: Raymond A. Pumphrey — ADDRESS: 934 Georgia Ave
(or) Warner E. Pumphrey, Inc. Silver Spring, Md.
25a. REC'D BY REGISTRAR: DATE MAR 29 '62
25b. REGISTRAR'S SIGNATURE: Arthur S. Kruse

**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. It should be retained by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7 61

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03453

# CERTIFICATE OF DEATH

03446

1. PLACE OF DEATH
a. COUNTY: Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 3days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Suburban Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: D.C.
b. COUNTY: - - -
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington D.C.
d. STREET ADDRESS: 4509 Butterworth Place, N.W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

47x3

3. NAME OF DECEASED (Type or print): First: Mary; Middle: F.; Last: Kelly

4. DATE OF DEATH: Month 3 - Day 10 - Year 1962

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 5/13/83
9. AGE (In years last birthday): 78 yrs. | IF UNDER 1 YEAR: Months, Days | IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE
10b. KIND OF BUSINESS OR INDUSTRY: - - -
11. BIRTHPLACE (County & State or foreign country): WASHINGTON D.C.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: ANDREW MILLS
14. MOTHER'S MAIDEN NAME: ELIZABETH AHERN.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service): No
16. SOCIAL SECURITY NO.:
17. INFORMANT: MARGT KELLY Address: 4509 Butterworth Pl. N.W. D.C.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pulmonary infarct, rt. lower lobe — INTERVAL BETWEEN ONSET AND DEATH
DUE TO (b) Thrombosis, pulmonary artery, rt. lower
DUE TO (c)

465X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Arteriosclerotic heart disease

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (~~the hospital~~) attended the deceased from 3/1, 1962 to 3/10, 1962, that (I) (~~we~~) last saw the deceased alive on 3/10 1962 and that death occured at 9PM, from the causes and on the date stated above.

22a. SIGNATURE: Marvin Wadler M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type): Dr. Marvin Wadler
22d. ADDRESS: 8816 Maywd. Ave., Silver Spring

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 3-14-1962
23c. NAME OF CEMETERY OR CREMATORY: Mt. Olivet Cemetery
23d. LOCATION (City, town or county): Washington, D. C. (State)

24. FUNERAL DIRECTOR'S SIGNATURE: Jos. Gawler Sons Inc.
ADDRESS: 1756 P.A. AVE. NW. WASH. D.C.
25a. REC'D BY REGISTRAR: DATE MAR 13 '62
25b. REGISTRAR'S SIGNATURE: Arthur L. Nieuwe

TO HOSPITAL PHYSICIAN: The law requires that the death certificate be executed by the attending physician within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03454 **CERTIFICATE OF DEATH** 03447

**1. PLACE OF DEATH**
a. COUNTY: Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Kensington
c. LENGTH OF STAY IN Md: 20 months
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Kensington Gardens Nursing Home

**2. USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring, ~~Maryland~~
d. STREET ADDRESS: 1515 E. Falkland Lane
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

**3. NAME OF DECEASED** (Type or print): First: Edith; Middle: W.; Last: Kidwell

**4. DATE OF DEATH**: Month: March; Day: 10; Year: 1962

**5. SEX**: female
**6. COLOR OR RACE**: white
**7. MARRIED** ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐
**8. DATE OF BIRTH**: Oct. 27, 1882
**9. AGE** (In years last birthday): 79 yrs. IF UNDER 1 YEAR: Months / Days; IF UNDER 24 HRS.: Hours / Min.

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): Housewife
**10b. KIND OF BUSINESS OR INDUSTRY**: Own home
**11. BIRTHPLACE** (County & State or foreign country): Washington, D.C.
**12. CITIZEN OF WHAT COUNTRY?**: U.S.A.

**13. FATHER'S NAME**: Grenville Whitaker
**14. MOTHER'S MAIDEN NAME**: Laura S. Clark

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unknown) (If yes give wars or dates of service): No — None
**16. SOCIAL SECURITY NO.**: 577-05-2097P
**17. INFORMANT**: Robert W. Kidwell
Address: 314 Northwest Dr. Silver Spring Md.

**18. CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
(a) IMMEDIATE CAUSE: Acute Cardiac Failure — INTERVAL BETWEEN ONSET AND DEATH: 1 day
DUE TO
(b): Arteriosclerotic Heart Disease — ?
DUE TO
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

**19. WAS AUTOPSY PERFORMED?** YES ☐ NO ☒

MEDICAL CERTIFICATION

**20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)
**20b. DESCRIBE HOW INJURY OCCURRED.** (Enter nature of injury in Part I or Part II of Item 18.)
**20c. TIME OF INJURY** Hour a.m. p.m. Month, Day, Year 19
**20d. INJURY OCCURRED** While at work ☐ Not While at work ☐
**20e. PLACE OF INJURY** (Home, farm, factory, street, office bldg., etc.)
**20f.** (City or town) (County) (State)

**21. I certify** that (I) (this hospital) attended the deceased from ..... 1950 to March 10, 1962 that (I) (we) last saw the deceased alive on March 10 1962, and that death occured at 10 P.M. from the causes and on the date stated above.

**22a. SIGNATURE**: J. Marion Bankhead M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
**22b. DATE SIGNED**: 3/10/62
**22c. PHYSICIAN'S NAME** (Type): J. Marion Bankhead
**22d. ADDRESS**: 9241 Col. Blv'd Silver Spring, Md.

**23a. BURIAL, CREMATION, REMOVAL** (Specify): Burial
**23b. DATE THEREOF**: 3-13-62
**23c. NAME OF CEMETERY OR CREMATORY**: Rock Creek Cemetery
**23d. LOCATION** (City, town or county): Washington, D.C. (State)

**24 FUNERAL DIRECTOR'S SIGNATURE**: Raymond A. Fiske
ADDRESS: 8434 Georgia Ave
Warner E. Pumphrey, Inc. Silver Spring, Maryland

**25a. REC'D BY REGISTRAR** DATE: MAR 13 '62
**25b. REGISTRAR'S SIGNATURE**: Carlton S. Kruse

**TO HOSPITAL PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 is to be retained by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

FOR STATE HEALTH DEPT.

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03455 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 03448

1. PLACE OF DEATH
a. COUNTY: Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Clarksburg (rural)
c. LENGTH OF STAY IN 1b: MARYLAND
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Johnson Rd

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Md
b. COUNTY: Montg
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Clarksburg
d. STREET ADDRESS: Johnson Rd
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Ernest Middle: W. Last: King
4. DATE OF DEATH: Month: Mar. Day: 1 Year: 1962
5. SEX: male
6. COLOR OR RACE: white
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 10-28-82
9. AGE (In years last birthday): 79 yrs. | IF UNDER 1 YEAR: Months, Days | IF UNDER 24 HRS.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer
10b. KIND OF BUSINESS OR INDUSTRY: Own farm
11. BIRTHPLACE (State or foreign country): Md
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: John B King
14. MOTHER'S MAIDEN NAME: Lilly Burns
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No | (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: Yes
17. INFORMANT: Lee King — Cedar Grove, Md — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: sudden
DUE TO (b): hypertension — yrs
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
+201

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Frank J. Brosnahan M.D.
EXAMINER'S NAME (Type): FRANK J. BROSNAHAN
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county):
DATE SIGNED: 3-1-62

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 3/3/62
22c. NAME OF CEMETERY OR CREMATORY: Bethesda Methodist
22d. LOCATION (City, town, or country): Brookingsville, Md. (State)

23. FUNERAL DIRECTOR: Olin L. Molesworth
ADDRESS: Damascus, Md.
24a. REC'D BY REGISTRAR: DATE MAR 5 '62
24b. REGISTRAR'S SIGNATURE: William S. Krause

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If an autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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5M 9/60

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# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03456 **CERTIFICATE OF DEATH** 03449

**1. PLACE OF DEATH**
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: 6 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Walter Reed Hosp

**2. USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Mont.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
d. STREET ADDRESS: 10400 Colesville Rd
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Matilda Middle ~~Autola~~ Last Kinsman
4. DATE OF DEATH: Month March Day 16 Year 1962
5. SEX: F
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 8-23-~~1872~~ 72
9. AGE (In years last birthday): 89 yrs — IF UNDER 1 YEAR: Months ___ Days ___ IF UNDER 24 HRS.: Hours ___ Min. ___
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: own home
11. BIRTHPLACE (County & State, or foreign country): D.C.
12. CITIZEN OF WHAT COUNTRY? American
13. FATHER'S NAME: Oliver Kinsman
14. MOTHER'S MAIDEN NAME: Emma Richardson
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No (If yes give war or dates of service): None
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Hosp Record — Address

**MEDICAL CERTIFICATION**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac decompensation — INTERVAL BETWEEN ONSET AND DEATH: 2 mos

DUE TO (b) Generalized arteriosclerosis — many years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Pneumonitis; acute renal failure

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from January, 1962 to March 16, 1962 that (I) (we) last saw the deceased alive on March 15, 1962, and that death occured at 5:00 AM, from the causes and on the date stated above.

22a. SIGNATURE: Bennet A. Porter Jr. M.D. — ATTENDING PHYS. ☒ MED DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: March 16, '62
22c. PHYSICIAN'S NAME (Type): Bennet A. Porter, Jr. M.D.
22d. ADDRESS: 9301 Colesville Rd., Silver Spring, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 3-19-62
23c. NAME OF CEMETERY OR CREMATORY: Parklawn Cemetery
23d. LOCATION (City, town or county) (State): Rockville Montgomery Co, Maryland

24 FUNERAL DIRECTOR'S SIGNATURE: Raymond A. Pfisterer — ADDRESS: 8434 Georgia Ave.
Warner E. Pumphrey, Inc., Silver Spring, Maryland
REC'D BY REGISTRAR: DATE MAR 19 '62
25b. REGISTRAR'S SIGNATURE: Thos. E. Kraus

**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
1SM 7/61

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03457 **CERTIFICATE OF DEATH** 03450

1. PLACE OF DEATH
a. COUNTY: Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Olney
c. LENGTH OF STAY IN Md: MARYLAND
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Montgomery General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Howard
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glenwood
d. STREET ADDRESS: 13 X 2
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: NELLIE Middle: CATHERINE Last: KRAMER

4. DATE OF DEATH: Month 3 Day 7 Year 1962

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 1-2-1890
9. AGE (In years last birthday): 72 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Basil H. Grimes
14. MOTHER'S MAIDEN NAME: Ida Tasker

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
16. SOCIAL SECURITY NO.: ?
17. INFORMANT: Mr. Fred Kramer (Husband) Address: Glenwood, Md

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary Thrombosis, Cortex
DUE TO (b) Atherosclerosis, hypertension, Cerebral
DUE TO (c) failure, Cardiac Arrest -
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: 1960 to 1962

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 1960 19..., to 7 March 19 62 that (I) (we) last saw the deceased alive on 7 March 1962 19..., and that death occured at 5:00 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Howard E. Hall M.D.
22b. DATE SIGNED: 7 March 62
22c. PHYSICIAN'S NAME (Type)
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22d. ADDRESS: Ashville, Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 3-10-62
23c. NAME OF CEMETERY OR CREMATORY: Providence
23d. LOCATION (City, town or county) (State): Glenelg, Md

24. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: F.C. Higinbotham, Ellicott City, Md

25a. REC'D BY REGISTRAR DATE MAR 12 '62
25b. REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. See page 4 retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7 61

# MARYLAND STATE DEPARTMENT OF HEALTH

**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

03458 **CERTIFICATE OF DEATH** 03451

Item 23b, Film G508 3/12/62 iwk

1. PLACE OF DEATH
a. COUNTY: Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda (rural)
c. LENGTH OF STAY IN 1b: 10 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): U.S. Naval Hospital, NNMC

MARYLAND

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chevy Chase
d. STREET ADDRESS: 5053 Bradley Boulevard
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Michael; Middle: Benjamin; Last: Krom
4. DATE OF DEATH: Month: March; Day: 1; Year: 1962
5. SEX: Male
6. COLOR OR RACE: Cauc
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 19 November 1960
9. AGE (In years last birthday): 1 yrs; IF UNDER 1 YEAR: Months, Days; IF UNDER 24 HRS.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): - - - -
10b. KIND OF BUSINESS OR INDUSTRY: - - - -
11. BIRTHPLACE (County & State, or foreign country): North Carolina
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Byron Earnest Krom
14. MOTHER'S MAIDEN NAME: Adlyn Lee
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Father: Byron Earnest Krom, same as #2 — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Hand-Schuller Christian Dis. — INTERVAL BETWEEN ONSET AND DEATH: 6 mo.

289.0

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m; Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 17 February, 1962, to 1 March, 1962, that (I) (we) last saw the deceased alive on 1 March 19 62, and that death occured at 1610 hrs from the causes and on the date stated above.

22a. SIGNATURE: H. A. Pearson
22b. DATE SIGNED: 2 March 1962
22c. PHYSICIAN'S NAME (Type): H.A. PEARSON, LCDR MC USN
M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS ☒
22d. ADDRESS: U.S. Naval Hospital

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: March 5, 1962
23c. NAME OF CEMETERY OR CREMATORY: Arlington National
23d. LOCATION (City, town or county) (State): Arlington, Virginia

24. FUNERAL DIRECTOR'S SIGNATURE: Robert A. Pumphrey
ADDRESS: Bethesda, Md.
Robert A. Pumphrey Funeral Home, 7557 Wisc. Ave.

25a. REC'D BY REGISTRAR DATE: MAR 5 '62
25b. REGISTRAR'S SIGNATURE: William S. Kruse

**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completed, filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7-61

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03459

## CERTIFICATE OF DEATH

03452

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 1 should be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): GERMANTOWN
c. LENGTH OF STAY IN 1b: 7 yrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MARYLANDER REST HOME

2. USUAL RESIDENCE (Where deceased lived, if institution, Residence Before Admission)
a. STATE
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): WASHINGTON D.C. 41x-3
d. STREET ADDRESS: 532-20TH ST. N.W.
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: ZERA — Middle: A. — Last: KULLMAN

4. DATE OF DEATH: Month: MARCH — Day: 6 — Year: 1962.

5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]
8. DATE OF BIRTH: AUG. 3, 1871
9. AGE (In years last birthday): 90 yrs.
IF UNDER 1 YEAR: Months | Days
IF UNDER 24 HRS.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): WASH. D.C.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: ? BEACH
14. MOTHER'S MAIDEN NAME: MARY M. POSEY

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): NO (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: NONE
17. INFORMANT: ESTHER KULLMAN — Address: 2D

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
(a) IMMEDIATE CAUSE: Gangrene, rt. leg. — INTERVAL BETWEEN ONSET AND DEATH: 2 days
(b) DUE TO: Embolus, rt. femoral artery — 2 days
(c) DUE TO: Arteriosclerotic cardiovascular disease — 10 days

422

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [ ]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work [ ] Not While at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from June 7, 1956 to March 6, 1962 that (I) (~~last~~) last saw the deceased alive on March 5, 1962 and that death occured at 11 AM, from the causes and on the date stated above.

22a. SIGNATURE: James D. Kerr M.D. — M.D
ATTENDING PHYS. [X] MED DIRECTOR [ ] STAFF PHYS. [ ]
22b. DATE SIGNED: 3/6/61
22c. PHYSICIAN'S NAME (Type): JAMES D. KERR M.D.
22d. ADDRESS: DAMASCUS, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 3/9/62
23c. NAME OF CEMETERY OR CREMATORY: CONGRESSIONAL CEM
23d. LOCATION (City, town or county) (State): WASH D.C.

24. FUNERAL DIRECTOR'S SIGNATURE: Timothy Hanlon — ADDRESS: 4748 - WISC. AVE. N.W.
25a. REC'D BY REGISTRAR DATE: MAR 9 '62
25b. REGISTRAR'S SIGNATURE: Arthur B. Hanna

1

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03460

## CERTIFICATE OF DEATH

03453

M

**1. PLACE OF DEATH**
a. COUNTY: Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN MARYLAND: 5 mo.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Washington San + Hosp.

**2. USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
d. STREET ADDRESS: 1020 University Blvd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

**3. NAME OF DECEASED** (Type or print): First: George; Middle: Lyman; Last: Lamb

**4. DATE OF DEATH**: Month: March; Day: 4; Year: 1962

**5. SEX**: Male

**6. COLOR OR RACE**: White

**7. MARRIED** ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

**8. DATE OF BIRTH**: 10-23-78

**9. AGE** (In years last birthday): 85 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): Government ?

**10b. KIND OF BUSINESS OR INDUSTRY**: Retired Fed Gov't

**11. BIRTHPLACE** (County & State, or foreign country): D.C.

**12. CITIZEN OF WHAT COUNTRY?**: U.S.A.

**13. FATHER'S NAME**: Lyman H. Lamb

**14. MOTHER'S MAIDEN NAME**: Martha Wright

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unkown): NO
(If yes give wars or dates of service)

**16. SOCIAL SECURITY NO.**

**17. INFORMANT**: Patients Chart
Address

MEDICAL CERTIFICATION

**18. CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute congestive heart failure
DUE TO (b): Arteriosclerotic heart disease
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: 1/2 hrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Carcinoma of bladder

**19. WAS AUTOPSY PERFORMED?** YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

**21. I certify** that (I) (this hospital) attended the deceased from [redacted]-11-29-61 19[redacted] to [redacted]-12-14-61 19[redacted] that (I) (we) last saw the deceased alive on 12-14 1961, and that death occured at 9 PM, from the causes and on the date stated above.

22a. SIGNATURE: Arthur J. Wilets M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type): Arthur J. Wilets
22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 3-7-62
23c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Cemetery
23d. LOCATION (City, town or county): Suitland (State): Maryland

24. FUNERAL DIRECTOR'S SIGNATURE: Deal Funeral Home
ADDRESS: Wash. D.C.

25a. REC'D BY REGISTRAR DATE MAR 9 '62
25b. REGISTRAR'S SIGNATURE: [illegible]

**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

03461 03454

**1. PLACE OF DEATH**
a. COUNTY: Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Kensington
c. LENGTH OF STAY IN MARYLAND: 18 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Carroll Hall Nursing Home

**2. USUAL RESIDENCE** (Where deceased lived, if institutional residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 34 Silver Spring
d. STREET ADDRESS: 12,502 Denley Road
a. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Lilian Middle: Mary Last: LAMB
4. DATE OF DEATH: Month: 26 March Day: Year: 1962
5. SEX: F
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: June 14, 1869
9. AGE (In years last birthday): 92 yrs. IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Sect and clerk Ret.
10b. KIND OF BUSINESS OR INDUSTRY: U.S.Navy Department
11. BIRTHPLACE (County & State, or foreign country): Washington, D.C.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: (unknown) Lamb
14. MOTHER'S MAIDEN NAME: Unknown
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service): None
16. SOCIAL SECURITY NO: None
17. INFORMANT: Mrs. Louise Darling Address: 12,502 Denley Rd, Silver Spring, Md.

**MEDICAL CERTIFICATION**

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a): CONGESTIVE FAILURE — INTERVAL BETWEEN ONSET AND DEATH: 2 wks
DUE TO (b): ASCVD — yrs
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Senility; Thrombophlebitis
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Jan. 30, 1962 to 26 Mar 1962 that (I) (~~this~~ last saw the deceased alive on 22 Mar 1962 and that death occured at 1:25 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Horace W. Bernton, M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 3/26/62
22c. PHYSICIAN'S NAME (Type): Horace W. Bernton
22d. ADDRESS: 4743 Bradley Blvd., Chevy Chase, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 3-28-62
23c. NAME OF CEMETERY OR CREMATORY: Fort Lincoln Cemetery
23d. LOCATION (City, town or county) (State): Prince George's County, Md.

24 FUNERAL DIRECTOR'S SIGNATURE: Raymond A. Zieka ADDRESS: 8434 Georgia Ave.
Warner E. Pumphrey, Inc. Silver Spring, Maryland
25a. REC'D BY REGISTRAR DATE: MAR 30 '62
25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

**TO HOSPITAL PHYSICIAN:** The law requires that the death certificate be executed 24 hours after death. If retained by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

17

M

I

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03452

## CERTIFICATE OF DEATH

03455

1. PLACE OF DEATH
a. COUNTY: Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rockville
c. LENGTH OF STAY IN 1b: MARYLAND
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 11912 Rockinghorse Road

2. USUAL RESIDENCE (Where deceased lived, If institution, residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 12 Rockville
d. STREET ADDRESS: 11912 Rockinghorse Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First MARY Middle L. Last LAWSON

4. DATE OF DEATH: Month MARCH Day 25 Year 1962

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 10/8/1900
9. AGE (In years last birthday): 61 yrs. IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Richard B. Pace
14. MOTHER'S MAIDEN NAME: Mildred E. Bowen
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
16. SOCIAL SECURITY NO. (If yes give war or dates of service)
17. INFORMANT: Roy J. Lawson-Husband Address: same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gastric carcinoma
DUE TO (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)
INTERVAL BETWEEN ONSET AND DEATH: 2 mos.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Rheumatic heart disease
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 2/ 1961, to 3/25/, 1962 that (I) (we) last saw the deceased alive on 3/23/ 1962 and that death occured at 10:45 AM, from the causes and on the date stated above.

22a. SIGNATURE: Donald Nelson M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 3/25/62
22c. PHYSICIAN'S NAME (Type)
22d. ADDRESS: 10620 Georgia Ave., Silver Spring, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 3/29/62
23c. NAME OF CEMETERY OR CREMATORY: Washington National
23d. LOCATION (City, town or county): Suitland (State): Md
24. FUNERAL DIRECTOR'S SIGNATURE: Lee Funeral Home
ADDRESS: 300 4th NE D.C.
25a. REC'D BY REGISTRAR DATE MAR 28 '62
25b. REGISTRAR'S SIGNATURE: Arthur S. Thomas

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 is retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03463

## CERTIFICATE OF DEATH

Reg. Dist. No. 03456

1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney
c. LENGTH OF STAY IN 1b 7wks.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Brooke Grove Foundation

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rockville
d. STREET ADDRESS Luckett Ave. P.O. Box 501
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print) First Lucy Middle Anne Last Lewis
4. DATE OF DEATH Month March Day 28 Year 1962

5. SEX F
6. COLOR OR RACE W
7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH 3-13-1879
9. AGE (In years last birthday) 83 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Culpepper-
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Benjamin Franklin Myers
14. MOTHER'S MAIDEN NAME Evelyn Brown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) — (If yes, give war or dates of service) —
16. SOCIAL SECURITY NO. —
17. INFORMANT Evelyn K. Gore Address 11601 Nairn Rd. Silver Spring, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident

DUE TO (b) Generalized Arteriosclerosis

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Bronchopneumonia

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year, Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 2-4-, 1962, to 3-28-, 1962, that I last saw the deceased alive on 2-25-, 1962, and that death occurred at 10 39 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE Joseph E. Smith, Jr. M.D. ADDRESS (Street, city or town, state) Burtonsville, Md. DATE SIGNED 3/28/62

PHYSICIAN'S NAME (Type) Joseph E. Smith, Jr. Burtonsville, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF March 31, 1962
22c. NAME OF CEMETERY OR CREMATORY Hopewell Church Cem.
22d. LOCATION (City, town, or county) (State) Lignum Virginia

23. FUNERAL DIRECTOR'S SIGNATURE Tyson Wheeler Per A. Blank ADDRESS East Montg. Ave. Rockville, Maryland
24a. REC'D BY REGISTRAR DATE APR 2 '62
24b. REGISTRAR'S SIGNATURE Carlton L. Rinna

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained from the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03464

## CERTIFICATE OF DEATH

03457

**1. PLACE OF DEATH**
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda (rural)
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): U. S. Naval Hospital, Bethesda, Md.

**2. USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
a. STATE: Virginia
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Alexandria
d. STREET ADDRESS: 3206 Wellington Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Paul — Middle: William — Last: LINDNER

4. DATE OF DEATH: Month: March — Day: 27 — Year: 1962

5. SEX: Male

6. COLOR OR RACE: Caucasion

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 6-10-78

9. AGE (In years last birthday): 84 yrs — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Elmont, L.I., N.Y.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: George Lindner

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No — (If yes give war or dates of service):

16. SOCIAL SECURITY NO.: 094 30 1168

17. INFORMANT: Hospital Records — Address:

**MEDICAL CERTIFICATION**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute myelomonoblastic Leukemia
DUE TO (b) Pneumonia
DUE TO (c)

204.3

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

d. INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1a:

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 1-23-62, 19, to 3-27-62, 19, that (I) (we) last saw the deceased alive on 27 March 19.62, and that death occured at 640PM, from the causes and on the date stated above.

22a. SIGNATURE: W. F. Warrender M D

22b. DATE SIGNED: March 28, 1962

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22c. PHYSICIAN'S NAME (Type): W. F. WARRENDER LT MC USN

22d. ADDRESS: U.S. Naval Hospital, Bethesda, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF:

23c. NAME OF CEMETERY OR CREMATORY: Smithtown

23d. LOCATION (City, town or county) (State): Smithtown L.I., NY.

24. FUNERAL DIRECTOR'S SIGNATURE: Robert A. Pumphrey

ADDRESS: Bethesda, Md.

Robert A. Pumphrey Funeral Home, 7557 Wisc., Ave

25a. REC'D BY REGISTRAR DATE: MAR 30 '62

25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 7 61

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03465 **CERTIFICATE OF DEATH** 03458

**1. PLACE OF DEATH**
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

**2. USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
e. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 4 Silver Spring
d. STREET ADDRESS: 600 McNeill Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

**3. NAME OF DECEASED** (Type or print): First: Paul; Middle:; Last: Lindsey

**4. DATE OF DEATH**: Month: March; Day: 5; Year: 1962

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 9-12-1896
9. AGE (In years last birthday): 65 yrs.
IF UNDER 1 YEAR: Months: ; Days:
IF UNDER 24 HRS.: Hours: ; Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED COMMERCE COM. US GOV
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: James E. Lindsey
14. MOTHER'S MAIDEN NAME: Mary J. Kirk

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown):
(If yes give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Belle H. Lindsey — Address: 600 McNeill Rd, Sil Sp., Md

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute coronary thrombosis
DUE TO (b)
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: 15 minutes

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.):
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 1954, 19, to March 5, 1962, that (I) (we) last saw the deceased alive on March 1 1962, and that death occured at 9:15 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Bennet A. Porter Jr M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: March 5, 1962
22c PHYSICIAN'S NAME (Type): Bennet A. Porter, Jr, M.D.
22d. ADDRESS: 9301 Colesville Rd, Silver Spring, Md.

23a. BURIAL, CREMATION REMOVAL (Specify): Burial
23b. DATE THEREOF: 3-7-62
23c. NAME OF CEMETERY OR CREMATORY: Presbyterian Cemetery
23d. LOCATION (City, town or county) (State): Alexandria Virginia

24 FUNERAL DIRECTOR'S SIGNATURE: Deal Funeral Home
ADDRESS: 4012 Ca Ave N.W., Wash. DC
25a. REC'D BY REGISTRAR DATE MAR 9 '62
25b. REGISTRAR'S SIGNATURE: [illegible]

**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed [illegible] 24 hours after death. Page [illegible] be retained by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completed [illegible] in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
15M 7/61

# MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

03466 **CERTIFICATE OF DEATH** 03459

1. PLACE OF DEATH a. COUNTY: Montgomery MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
c. LENGTH OF STAY IN 1b: 12 yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Md b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 1b Silver Spring
d. STREET ADDRESS: 869 Northampton
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Ella Middle: May Last: Lodge
4. DATE OF DEATH: Month: Mar Day: 29 Year: 1962
5. SEX: Fem
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Oct 20 1877
9. AGE (In years last birthday): 84 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? US
13. FATHER'S NAME: John T Conner
14. MOTHER'S MAIDEN NAME: Mary Eliz. Brown
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mrs M Lodge Kurland, 869 Northampton, Silver Spring Md

MED. CA. CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Embolism — INTERVAL BETWEEN ONSET AND DEATH 3/25/62
DUE TO (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) Cor. Fibrillation — 6 Mo
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I **certify** that (I) (this hospital) attended the deceased from 3/17/ 1962 to 3/29/ 1962 that (I) (we) last saw the deceased alive on 3/27/ 1962 and that death occurred at 7 P.M., from the causes and on the date stated above.

22a. SIGNATURE: [illegible] M.D.
ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED: 3/29/62
22c. PHYSICIAN'S NAME (Type): Howard T. Moore
22d. ADDRESS: 7030 Carroll Ave Takoma Park Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: March 31, 1962
23c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Cemetery
23d. LOCATION (City, town, or county) (State): Prince Geo. County, Maryland
24. FUNERAL DIRECTOR'S SIGNATURE: J. Arthur Walters ADDRESS: 254 Carroll St NW Wash. DC
25a. REC'D BY REGISTRAR DATE APR 2 '62
25b. REGISTRAR'S SIGNATURE: Arthur S. Kruse

TO HOSPITAL [illegible]NDING PHYSICIAN: The law requires that the death certificate be executed within 24 ho[illegible]er death. Page 4 may be retai[illegible] hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death

VR A1S (4) 15M 9/59

**MARYLAND STATE DEPARTMENT OF HEALTH**

**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

03467

# CERTIFICATE OF DEATH

03460

1. PLACE OF DEATH
a. COUNTY: Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Kensington
c. LENGTH OF STAY IN 1b: 1 yr.
MARYLAND
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Kensington Gardens San

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rockville
d. STREET ADDRESS: 6300 Tilden Lane
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Reginald; Middle: B.; Last: Looker.

4. DATE OF DEATH: Month: 3; Day: 6; Year: 1962

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 2-21-73

9. AGE (In years last birthday): 89 yrs.

IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Bank Teller

10b. KIND OF BUSINESS OR INDUSTRY: Banking

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Thomas H. Looker

14. MOTHER'S MAIDEN NAME: L. Belgham

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): Yes (If yes give war or dates of service): Spanish Amer

16. SOCIAL SECURITY NO.: 577-22-1999

17. INFORMANT: Reginald B. Looker, Jr.-Son-same 2d Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bronchopneumonia
DUE TO (b): Diffuse bilateral pulmonary fibrosis
DUE TO (c): cause undetermined.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

INTERVAL BETWEEN ONSET AND DEATH: 6 days ?

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Generalized arteriosclerosis.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT, WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Mar 4 1959 to Mar 6 1962 that (I) (~~I~~) last saw the deceased alive on Mar 4 1962 and that death occured at 1 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Charles A. Gray Jr. MD

ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS ☐

22b. DATE SIGNED: 3/6/62

22c. PHYSICIAN'S NAME (Type): Charles A. Gray Jr. MD

22d. ADDRESS: 4740 Chevy Chase Dr. Ch. Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 3/8/62

23c. NAME OF CEMETERY OR CREMATORY: Arlington Nat. Cem

23d. LOCATION (City, town or county) (State): Arlington, Virginia

24. FUNERAL DIRECTOR'S SIGNATURE: Robert A. Pumphrey

ADDRESS: Bethesda, Maryland

25a. REC'D BY REGISTRAR DATE MAR 9 '62

25b. REGISTRAR'S SIGNATURE: Anthony S. Krause

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed in 24 hours after death. Page 4 should be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
1SM 7-61

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03468

# CERTIFICATE OF DEATH

03461

1. PLACE OF DEATH
a. COUNTY: Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN MARYLAND: 4 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): The Clinical Center, Bethesda 14, Md.

2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
d. STREET ADDRESS: 2425 Ross Road
e. IS RESIDENCE ON A FARM? YES [ ] NO [X]

3. NAME OF DECEASED (Type or print): First: Gordon; Middle: Truett; Last: Lovett

4. DATE OF DEATH: Month: March; Day: 5; Year: 1962

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH: June 29, 1926

9. AGE (In years last birthday): 35 yrs. IF UNDER 1 YEAR: Months / Days / IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Printer

10b. KIND OF BUSINESS OR INDUSTRY: Printing

11. BIRTHPLACE (County & State, or foreign country): Texas

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Charles Lovett

14. MOTHER'S MAIDEN NAME: Ida Martin

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)

16. SOCIAL SECURITY NO.: 451-32-1501

17. INFORMANT: The Medical Record
Address: The Clinical Center, Bethesda 14, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 4 days
DUE TO
(b) Hypertension — 5 years
DUE TO
(c) Diabetes Mellitus — 20 years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES [X] NO [ ]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED: While at work [ ] Not While at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from March 1, 1962, to March 5, 1962 that (I) (we) last saw the deceased alive on March 5, 1962, and that death occured at 5:50 A.M. from the causes and on the date stated above.

22a. SIGNATURE: Samuel Barondes M.D.

22b. DATE SIGNED: March 9, 1962

ATTENDING PHYS. [ ] MED. DIRECTOR [ ] STAFF PHYS. [X]

22c. PHYSICIAN'S NAME (Type): Samuel Barondes, M.D.

22d. ADDRESS: The Clinical Center, National Institutes of Health, Bethesda 14, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 3/9/62

23c. NAME OF CEMETERY OR CREMATORY: Memo. Gardens

23d. LOCATION (City, town or county) (State): Amarillo, Texas

24. FUNERAL DIRECTOR'S SIGNATURE: W. W. Chambers Co.
ADDRESS: 8655 Ga. Ave. Silver Spring Md

25a. REC'D BY REGISTRAR DATE: MAR 12 '62

25b. REGISTRAR'S SIGNATURE: [illegible]

TO FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.

TO ATTENDING PHYSICIAN: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03469

## CERTIFICATE OF DEATH

03462

**1. PLACE OF DEATH**
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): OLNEY
c. LENGTH OF STAY IN 1b: 17 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MONTGOMERY GENERAL HOSPITAL

**2. USUAL RESIDENCE** (Where deceased lived, if institution, Residence before admission)
a. STATE: MARYLNAD
b. COUNTY: MONTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X GAITHERSBURG
d. STREET ADDRESS: Rt. 2
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

**3. NAME OF DECEASED** (Type or print): First: SETH — Middle: HASKELL — Last: LOW

**4. DATE OF DEATH**: Month: 3 — Day: ~~20~~ 30 — Year: 62 — 19

5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: 5-20-11
9. AGE (In years last birthday): 50 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED-Biologist
10b. KIND OF BUSINESS OR INDUSTRY: Wild Life
11. BIRTHPLACE (County & State, or foreign country): MASS.
12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME: RUSSELL C. LOW
14. MOTHER'S MAIDEN NAME: ALICE KEITH PRESCOTT
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): no
16. SOCIAL SECURITY NO. (If yes give war or dates of service): 215-36-3983
17. INFORMANT: HOSPITAL RECORDS — Address

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Embolus — INTERVAL BETWEEN ONSET AND DEATH: 2 days

DUE TO (b) Astrocytoma of Rt Cerebrum

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) 1yr

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES [X] NO [ ]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED While at work [ ] Not While at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 3/13 62, to 3/30 62, that (I) (we) last saw the deceased alive on 3/29 62 and that death occured at 5:05A M, from the causes and on the date stated above.

22a. SIGNATURE: C. H. Ligon
22b. DATE SIGNED: 3/30/62
22c. PHYSICIAN'S NAME (Type): CHARLES H. LIGON, M.D.
22d. ADDRESS: SANDY SPRING, MARYLAND
ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]

23a. BURIAL, CREMATION, REMOVAL (Specify): Cremation 3-31-62
23b. DATE THEREOF
23c. NAME OF CEMETERY OR CREMATORY: Ft. Lincoln
23d. LOCATION (City, town or county): Prince George Co. (State): Maryland

24. FUNERAL DIRECTOR'S SIGNATURE: Francis H. Barber
ADDRESS: Laytonsville, Md.

25a. REC'D BY REGISTRAR: DATE APR 3 '62
25b. REGISTRAR'S SIGNATURE: Arthur L. [illegible]

**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 1 should be retained by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7 61

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FOR STATE HEALTH DEPT.

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2

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03470

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03463

1. PLACE OF DEATH
a. COUNTY: Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rockville (rural)
c. LENGTH OF STAY IN 1b: MARYLAND 5yrs
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Dover Rd

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Md
b. COUNTY: Monty
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rockville
d. STREET ADDRESS: Dover Rd
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Robert Middle Luckett Last

4. DATE OF DEATH: Month Mar Day 24 Year 1962

5. SEX: male
6. COLOR OR RACE: col
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 2-2-1905
9. AGE (In years last birthday): 57 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): laborer
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Md
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John P. Luckett
14. MOTHER'S MAIDEN NAME: ~~Amanda~~ Amanda Nelson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give were or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Arzella L. Clark (sister) Address: Rockville Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral hemorrhage + laceration (left temporal lobe) — INTERVAL BETWEEN ONSET AND DEATH: Sudden
983X
DUE TO (b) Fracture of skull
DUE TO (c) Struck by a blunt instrument

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Repeatedly struck with a hammer at home
20c. TIME OF INJURY Hour a.m. 3:55 Month, Day, Year 3-24 1962
20d. INJURY OCCURRED While at work ☐ Not While at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) home
20f. (City or town) Rockville (County) Monty (State) Md

21. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinion death resulted from. Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐

ACTUAL SIGNATURE: Frank J. Bruschart M.D.
EXAMINER'S NAME (Type): FRANK J. BRUSCHART
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county)
DATE SIGNED: 3-24-62

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 3/28/62
22c. NAME OF CEMETERY OR CREMATORY: Arlington National.,
22d. LOCATION (City, town, or country): Arlington, Va. (State)

23. FUNERAL DIRECTOR: Robert L. Snowden, ADDRESS: Rockville, Md.
24a. REC'D BY REGISTRAR DATE MAR 29 '62
24b. REGISTRAR'S SIGNATURE: Lillian S. Hines

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any [illegible] is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AISME SM 9/60

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03471

## CERTIFICATE OF DEATH

03464

**1. PLACE OF DEATH**
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Kensington
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Carroll Hall Sanitarium

**2. USUAL RESIDENCE** (Where deceased lived, If institution, Residence before admission)
a. STATE: Virginia
b. COUNTY: Arlington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Arlington
d. STREET ADDRESS: 2411 N. Upshur Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

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**3. NAME OF DECEASED** (Type or print): First: JANE Middle: E. Last: McDONALD

**4. DATE OF DEATH**: Month: MARCH Day: 12 Year: 1962

**5. SEX**: Female

**6. COLOR OR RACE**: White

**7. MARRIED** ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

**8. DATE OF BIRTH**: 12-26-1878

**9. AGE** (In years last birthday): 83 yrs. IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS.: Hours / Min.

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): Housewife

**10b. KIND OF BUSINESS OR INDUSTRY**: - - -

**11. BIRTHPLACE** (County & State, or foreign country): England

**12. CITIZEN OF WHAT COUNTRY?**: U.S.A.

**13. FATHER'S NAME**: Thomas Martin Thompson

**14. MOTHER'S MAIDEN NAME**: Emma Brown

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**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unknown) (If yes give year or dates of service): No

**16. SOCIAL SECURITY NO.**: - - -

**17. INFORMANT**: Leone Robinson — Address: 2411 N. Upshur St. Arlington, Va.

**18. CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY-
IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC HEART DISEASE
DUE TO
(b) ESSENTIAL HYPERTENSION
DUE TO
(c) GENERALIZED ARTERIOSCLEROSIS

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): SENILITY

**19. WAS AUTOPSY PERFORMED?** YES ☐ NO ☒

MEDICAL CERTIFICATION

**20a. ACCIDENT WAS UNDERLYING** ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

**20b. DESCRIBE HOW INJURY OCCURED.** (Enter nature of injury in Part I or Part II of item 18.)

**20c. TIME OF INJURY** Hour a.m. p.m. Month, Day, Year 19

**20d. INJURY OCCURRED** While at work ☐ Not While at work ☐

**20e. PLACE OF INJURY** (Home, farm, factory, street, office bldg., etc.)

**20f.** (City or town) (County) (State)

C

**21. I certify** that (I) (~~this hospital~~) attended the deceased from Aug. 8, 1961, to MARCH 12, 1962, that (I) (~~we~~) last saw the deceased alive on MARCH 12 1962 and that death occured at 12:15 PM, from the causes and on the date stated above.

**22a. SIGNATURE**: Henry Lowder M.D.

ATTENDING PHYS. ☒ MED DIRECTOR ☐ STAFF PHYS. ☐

**22b. DATE SIGNED**: 3/12/62

**22c. PHYSICIAN'S NAME** (Type)

**22d. ADDRESS**: 5206 NORWAY DR, CHEVY CHASE, Md

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**23a. BURIAL, CREMATION, REMOVAL** (Specify): Removal

**23b. DATE THEREOF**: 3-13-1962

**23c. NAME OF CEMETERY OR CREMATORY**: Beech Woods Cemetery

**23d. LOCATION** (City, town or county) (State): Beech Woods, Pa.

**24 FUNERAL DIRECTOR'S SIGNATURE**: Joseph Hawkins Sons — ADDRESS: 1756 Pa. Ave. N.W. Wash. D.C.

**25a. REC'D BY REGISTRAR** DATE MAR 14 '62

**25b. REGISTRAR'S SIGNATURE**: [illegible]

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed in 24 hours after death. Page 4 be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

**MARYLAND STATE DEPARTMENT OF HEALTH**

**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

03472 **CERTIFICATE OF DEATH** 03465

**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 1 should be retained by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 M 73 1 2 1

1. **PLACE OF DEATH** a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): OLNEY
c. LENGTH OF STAY IN 1b: 5 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MONTGOMERY GENERAL HOSPITAL

2. **USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission) a. STATE: MARYLAND b. COUNTY: MONTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X CLARKSBURG
d. STREET ADDRESS: RT. 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First ELLIOTT Middle GRANVILLE Last MACE

4. **DATE OF DEATH** Month 3 Day 28 Year 19 62

5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 12-18-01
9. AGE (In years last birthday): 60 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): CARETAKER
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): WEST VIRGINIA
12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME: XXXXXX WILLIAM A. MACE
14. MOTHER'S MAIDEN NAME: ANNA McCLOUD
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: 232-03019
17. INFORMANT: HOSPITAL RECORDS Address

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH 5 days.
DUE TO (b) Arteriosclerosis — years.
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I.a: Arteriosclerotic Heart Disease.

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. [Enter nature of injury in Part I or Part II of item 18.]
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I **certify** that (I) (this hospital) attended the deceased from 3/23, 1962, to 3/28, 1962 that (I) (we) last saw the deceased alive on 3/28, 1962 and that death occured at 3:32 P.M., from the causes and on the date stated above.

22a. SIGNATURE: Richard A. Yates M.D. M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 3/29/62
22c. PHYSICIAN'S NAME (Type): RICHARD A. YATES, M.D.
22d. ADDRESS: OLNEY, MARYLAND

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 3/30/62
23c. NAME OF CEMETERY OR CREMATORY: Methodist
23d. LOCATION (City, town or county) (State): Clarksburg Md.

24 FUNERAL DIRECTOR'S SIGNATURE: William B. Hilton ADDRESS: Barnesville, Md.
25a. REC'D BY REGISTRAR DATE APR 2 '62
25b. REGISTRAR'S SIGNATURE: [illegible]

VR A15 (4)
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FOR STATE HEALTH DEPT.

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If [illegible] is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03473 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 03466

1. PLACE OF DEATH
a. COUNTY: Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): TAKOMA PARK
c. LENGTH OF STAY IN 1b: 1hr. 40min
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Washington Sanitarium and Hospital
MARYLAND

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): District of Columbia
d. STREET ADDRESS: 6106 1st Place N.E
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Edmund Middle: S. Last: Majchrzyk

4. DATE OF DEATH: Month: March Day: 25 Year: 1962

5. SEX: male
6. COLOR OR RACE: white
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: December 27, 1924
9. AGE (In years last birthday): 37 yrs.
IF UNDER 1 YEAR: Months: 2 Days: 26
IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Electrician
10b. KIND OF BUSINESS OR INDUSTRY: Construction
11. BIRTHPLACE (State or foreign country): New York City
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Stanley Majchrzyk
14. MOTHER'S MAIDEN NAME: Stella Kobra

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes give war or dates of service): W.W. II
16. SOCIAL SECURITY NO.:
17. INFORMANT: Nonnie Majchrzyk Address: 6106 1st Place N.E

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MASSIVE THORACIC AND ABDOMINAL HEMORRAGE — INTERVAL BETWEEN ONSET AND DEATH: 2 HOURS

816 X

DUE TO (b) CRUSHED CHEST AND RUPTURED SPLEEN — 〃

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c) AUTO ACCIDENT — 〃

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): FRACTURE LEFT HIP AND LEFT LOWER LEG

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.): Driver of car involved in head on collision
20c. TIME OF INJURY: Hour e.m. 12:05 p.m. Month, Day, Year: 3-25 1962
20d. INJURY OCCURRED While at work ☐ Not While at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Street
20f. (City or town): Chillum (County): P.G. (State): Md

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Frank J. Broschart M.D.
EXAMINER'S NAME (Type): FRANK J. BROSCHART

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county):

DATE SIGNED: 3-25-62

22a. BURIAL, CREMATION, REMOVAL (Specify): CREMATION
22b. DATE THEREOF: 3/26/1962
22c. NAME OF CEMETERY OR CREMATORY: FORT LINCOLN CREMATORY
22d. LOCATION (City, town, or country) (State): PRINCE GEORGES COUNTY, MARYLAND

23. FUNERAL DIRECTOR: Tony E. Hyong
ADDRESS: HYSONG'S FUNERAL HOME 1330 N. ST, N.W. - WASH. D.C.

24a. REC'D BY REGISTRAR: DATE MAR 28 '62
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

# MARYLAND STATE DEPARTMENT OF HEALTH

**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

03474 **CERTIFICATE OF DEATH** 03467

**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed in 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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1. **PLACE OF DEATH** a. COUNTY: Mont, — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Rockville
c. LENGTH OF STAY IN 1b: 1 Yr.
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address):

2. **USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Mont,
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rockville
d. STREET ADDRESS: 1210 Crawford Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Exie Middle: Salena Last: Mann
4. **DATE OF DEATH** Month: Mar Day: 10th Year: 19 2
5. SEX: Female 6. COLOR OR RACE: White 7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Feb 24-1879
9. AGE (In years last birthday): 83 yrs. IF UNDER 1 YEAR: Months 0 Days 28 IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State or foreign country): Lovettsville. Va,
12. CITIZEN OF WHAT COUNTRY? U S A
13. FATHER'S NAME: Charles K. Huff
14. MOTHER'S MAIDEN NAME: Etta S. Cooper
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mrs Lucille Graham. Address: Rockville. Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary occlusion — few minutes
DUE TO
(b) arteriosclerotic cardiovascular disease — 5 years
DUE TO
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): none

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Jan. 11, 1962 to March 16, 1962 that (I) (we) last saw the deceased alive on March 14, 1962 and that death occured at 10:25 A.M. from the causes and on the date stated above.

22a. SIGNATURE: W. A. Linthicum M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 5/16/62
22c. PHYSICIAN'S NAME (Type): Wm A. Linthicum
22d. ADDRESS: 110 S. Washington St. Rockville Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 3-19-62
23c. NAME OF CEMETERY OR CREMATORY: Lovettsville Union
23d. LOCATION (City, town or county) (State): Lovettsville. Va.

24 FUNERAL DIRECTOR'S SIGNATURE: Ernest C. Gartner. ADDRESS: Gaithersburg. Md.
25a. REC'D BY REGISTRAR DATE MAR 19 '62
25b. REGISTRAR'S SIGNATURE: [illegible]

VR A15 (4)
15M 7/61

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

03475 03468

**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 1 must be retained by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Montgomery
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN this place: 2 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): The Clinical Center, Bethesda 14, Md.

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Illinois
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Pekin
d. STREET ADDRESS: 1405 South Capitol Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Richard, Middle Allen, Last Manwarren
4. DATE OF DEATH: Month March, Day 3, Year 1962
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: March 24, 1932
9. AGE (In years last birthday): 29 yrs. IF UNDER 1 YEAR: Months, Days; IF UNDER 24 HRS.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Draftsman
10b. KIND OF BUSINESS OR INDUSTRY: Caterpillar tractors
11. BIRTHPLACE (County & State, or foreign country): Illinois
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Glenn A. Manwarren
14. MOTHER'S MAIDEN NAME: Mabel L. Irwin
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes
16. SOCIAL SECURITY NO.: Korean War
17. INFORMANT: Unavailable
Address: The Medical Record The Clinical Center, Bethesda 14, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): RENAL FAILURE — INTERVAL BETWEEN ONSET AND DEATH: 3 days
DUE TO (b): Chronic myelogenous leukemia — 14 months
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER):
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that ☒ (this hospital) attended the deceased from March 1, 1962 to March 3, 1962 that ☒ (we) last saw the deceased alive on March 3, 1962, and that death occured at 6:15 AM from the causes and on the date stated above.

22a. SIGNATURE: Thorne S. Winter, III M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: 3-3-62
22c. PHYSICIAN'S NAME (Type): Thorne S. Winter, III
22d. ADDRESS: The Clinical Center, National Institutes of Health, Bethesda 14, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial-Transit
23b. DATE THEREOF: 3/5/62
23c. NAME OF CEMETERY OR CREMATORY: Greenwood Cemetery
23d. LOCATION (City, town or county) (State): Canton, Illinois

24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Robert A. Pumphrey, Bethesda, Maryland
25a. REC'D BY REGISTRAR DATE MAR 7 '62
25b. REGISTRAR'S SIGNATURE: [illegible]

VR A15 (4)
15M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

03476 03469

1. PLACE OF DEATH
a. COUNTY: Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: 12hrs
MARYLAND
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Washington Sanitarium Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
d. STREET ADDRESS: 8604 Mayfair Place
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Nina Middle: Mary Last: Marinari

4. DATE OF DEATH: Month: 3 Day: 23 Year: 1962

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 8-8-99
9. AGE (In years last birthday): 63 yrs. IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Italy
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Vincent Juliano
14. MOTHER'S MAIDEN NAME: Rose (Unknown)
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Address: Pt's chart

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Hypertensive encephalopathy
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
INTERVAL BETWEEN ONSET AND DEATH:
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 3-22 1962 to 3-22 1962 that (I) (we) last saw the deceased alive on 3-22 1962 and that death occured at 8:45 A.M. from the causes and on the date stated above

22a. SIGNATURE: J. Merendino M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type): John J. Merendino M.D.
22d. ADDRESS: Silver Spring Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 3-26-62
23c. NAME OF CEMETERY OR CREMATORY: St. Mary's Cemetery
23d. LOCATION (City, town or county): Washington (State): D.C.

24. FUNERAL DIRECTOR'S SIGNATURE: F. J. Hoellins
ADDRESS: Wash. D.C. 3521-14th St. N.W.
25a. REC'D BY REGISTRAR: DATE MAR 27 '62
25b. REGISTRAR'S SIGNATURE: Clarence S. Kruse

TO ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03477 **CERTIFICATE OF DEATH** 03470

**1. PLACE OF DEATH**
a. COUNTY: Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 8 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Suburban
MARYLAND

**2. USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
a. STATE: West Virginia
b. COUNTY: Jefferson
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Harpers Ferry
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

**3. NAME OF DECEASED** (Type or print): First: Mayme Middle: M. Last: Marquette

**4. DATE OF DEATH** Month: March Day: 22 Year: 1962

**5. SEX:** Female

**6. COLOR OR RACE:** White

**7. MARRIED** ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

**8. DATE OF BIRTH:** 9/6/78

**9. AGE** (In years last birthday): 83 yrs. IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS.: Hours / Min.

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): Retired, Post Mistress U.S. Govt.

**10b. KIND OF BUSINESS OR INDUSTRY:**

**11. BIRTHPLACE** (County & State, or foreign country): Virginia

**12. CITIZEN OF WHAT COUNTRY?** USA

**13. FATHER'S NAME:** Thomas J. Burleigh

**14. MOTHER'S MAIDEN NAME:** Marthe Moore

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unknown): no (If yes give war or dates of service): no

**16. SOCIAL SECURITY NO**

**17. INFORMANT:** Cornelia M. Jones Address: Ch. Ch., Md. - 6921 Strathmore St.

**18. CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Metastatic Carcinoma, Lungs and Liver

DUE TO (b): Primary undetermined

DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: 3 mos.

PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

**19. WAS AUTOPSY PERFORMED?** YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I. or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

**21. I certify** that (I) (this hospital) attended the deceased from Sept. 19 59, to March 22 1962 that (I) (we) last saw the deceased alive on March 22 1962 and that death occured at 4:15 p.m. from the causes and on the date stated above.

22a. SIGNATURE: Michael M. Healy

22b. DATE SIGNED: 3/22/62

22c. PHYSICIAN'S NAME (Type): Michel M. HEALY, M.D

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22d. ADDRESS: WASHINGTON CLINIC WASH, 15 - DC

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 3/27/62

23c. NAME OF CEMETERY OR CREMATORY: St. Peters

23d. LOCATION (City, town or county) (State): Bolivar, W. Va.

24 FUNERAL DIRECTOR'S SIGNATURE: Tyson Wheeler ADDRESS: 1331 Edmonston Ave Rockville, Md.

25a. REC'D BY REGISTRAR DATE MAR 27 '62

25b. REGISTRAR'S SIGNATURE: Clifton S. Fraser

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

03478

## CERTIFICATE OF DEATH

03471

**1. PLACE OF DEATH**
a. COUNTY: Montgomery
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN MARYLAND: 745 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): The Clinical Center, Bethesda 14, Md.

**2. USUAL RESIDENCE** (Where deceased lived, If Institution: Residence before admission)
a. STATE: New Jersey
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Avenel,
d. STREET ADDRESS: 7 Manor Place
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

**3. NAME OF DECEASED** (Type or print): First: Gertrude; Middle: Josephine; Last: Marsh

**4. DATE OF DEATH**: Month: March; Day: 15; Year: 19 62

**5. SEX**: Female

**6. COLOR OR RACE**: White

**7. MARRIED** ☐ **NEVER MARRIED** ☒ **WIDOWED** ☐ **DIVORCED** ☐

**8. DATE OF BIRTH**: April 1903

**9. AGE** (In years last birthday): 5 yrs.

IF UNDER 1 YEAR: Months: ; Days:

IF UNDER 24 HRS.: Hours: ; Min:

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): Saleslady

**10b. KIND OF BUSINESS OR INDUSTRY**: Store

**11. BIRTHPLACE** (County & State, or foreign country): New Jersey

**12. CITIZEN OF WHAT COUNTRY?**: U.S.A.

**13. FATHER'S NAME**: William Marsh

**14. MOTHER'S MAIDEN NAME**: Madeline Mistler

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unknown): No

(If yes give war or dates of service):

**16. SOCIAL SECURITY NO.**: Not available

**17. INFORMANT**: The Medical Record, Address: The Clinical Center, Bethesda 14, Maryland

**MEDICAL CERTIFICATION**

**18. CAUSE OF DEATH** (Enter only one cause per line for (a) (b) and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) CIRCULATING anticoagulant I massive left retroperitoneal hemorrhage, peritoneal, pleural

DUE TO (b) atelectasis left lung

DUE TO (c) necrosis left kidney 2° pressure from hematoma

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: 2½ years; 4 days; 2 days; 4 days

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I a):

**19. WAS AUTOPSY PERFORMED?** YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from February 29, 1960 to March 15, 1962, that (I) (we) last saw the deceased alive on March 15 1962, and that death occured 4:00 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Louis M. Aledort, M.D.

22b. DATE SIGNED: March 16, 1962

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS ☒

22c. PHYSICIAN'S NAME (Type): Louis M. Aledort M.D.

22d. ADDRESS: The Clinical Center, National Institutes of Health, Bethesda 14, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial-transit 3-16-62

23b. DATE THEREOF

23c. NAME OF CEMETERY OR CREMATORY: St.Gertrude's Cemetery

23d. LOCATION (City, town or county): Colonia, New Jersey (State)

24. FUNERAL DIRECTOR'S SIGNATURE: ROBERT A. PUMPHREY

ADDRESS: Bethesda, Md.

25a. REC'D BY REGISTRAR: DATE MAR 20 '62

25b. REGISTRAR'S SIGNATURE: [illegible]

**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed in 24 hours after death. Page 4 should be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1 FOR STATE HEALTH DEPT.

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# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03479 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 03472

1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda
c. LENGTH OF STAY IN 1b D.O.A.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Suburban

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE Md. b. COUNTY Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring
d. STREET ADDRESS 4516 Randolph Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First: William Middle: Robert Last: Martin
4. DATE OF DEATH Month: 3 Day: 2 Year: 1962
5. SEX Male
6. COLOR OR RACE White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH April 17, 1938
9. AGE (In years last birthday) 23 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plumbers helper
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Pennsylvania
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME William Edward Martin
14. MOTHER'S MAIDEN NAME Winifred Mae Redwine
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes (If yes give war or dates of service) Navy 1955-1956
16. SOCIAL SECURITY NO.
17. INFORMANT Winifred Mae Crawford Address Mother

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute pulmonary edema
DUE TO (b) Bilateral Broncho-pneumonia, acute
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH sudden

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE Frank J. Blaschart M.D.
EXAMINER'S NAME (Type) FRANK J. Blaschart
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county)
DATE SIGNED Mar 3 1962

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 6 MAR 1962
22c. NAME OF CEMETERY OR CREMATORY Arlington
22d. LOCATION (City, town, or country) Arl. (State) Va.
23. FUNERAL DIRECTOR Francis Funeral Home
ADDRESS 7400 Ga. Ave. NW Wash. DC
REC'D BY REGISTRAR DATE MAR 7 '62
24b. REGISTRAR'S SIGNATURE

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any [illegible] is necessary, please execute [illegible] certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9,60

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# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03480 **CERTIFICATE OF DEATH** 03473

Item 5 Film 6400

**1. PLACE OF DEATH**
a. COUNTY: Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Suburban Hospital

**2. USUAL RESIDENCE** (Where deceased lived, If Institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 34 Silver Spring
d. STREET ADDRESS: 13106 Holdridge Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

**3. NAME OF DECEASED** (Type or print): First EDGAR Middle J. Last MATTINGLY

**4. DATE OF DEATH**: Month March Day 16, Year 1962

**5. SEX**: Male Female

**6. COLOR OR RACE**: White

**7. MARRIED** ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

**8. DATE OF BIRTH**: Feb. 13, 1882

**9. AGE** (In years last birthday): 80 yrs

IF UNDER 1 YEAR: Months 1 Days 3

IF UNDER 24 HRS: Hours Min.

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): Ret. Railroad

**10b. KIND OF BUSINESS OR INDUSTRY**: Railroading

**11. BIRTHPLACE** (County & State, or foreign country): Illinois

**12. CITIZEN OF WHAT COUNTRY?**: USA

**13. FATHER'S NAME**: David Mattingly

**14. MOTHER'S MAIDEN NAME**: Unknown

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unkown) (If yes give wars or dates of service):

**16. SOCIAL SECURITY NO.**:

**17. INFORMANT** Address:

MEDICAL CERTIFICATION

**18. CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pulmonary edema. — INTERVAL BETWEEN ONSET AND DEATH: 4 hrs.

DUE TO (b)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c) Heart failure

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

**19. WAS AUTOPSY PERFORMED?** YES ☐ NO ☒

**20a. ACCIDENT WAS UNDERLYING** ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

**20b. DESCRIBE HOW INJURY OCCURRED.** (Enter nature of injury in Part I or Part II of item 18.)

**20c. TIME OF INJURY** Hour a.m. p.m. Month, Day, Year 19

**20d. INJURY OCCURRED** While at work ☐ Not While at work ☐

**20e. PLACE OF INJURY** (Home, farm, factory, street, office bldg., etc.)

**20f.** (City or town) (County) (State)

**21. I certify** that (I) (~~this hospital~~) attended the deceased from 3/16/62, 19..., to 3/16/62, 19, that (I) (~~we~~) last saw the deceased alive on 3/16/62, 19..., and that death occured at 1:15 PM, from the causes and on the date stated above.

**22a. SIGNATURE** A W Smith

MD ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

**22b. DATE SIGNED** Mar. 16, 1962

**22c. PHYSICIAN'S NAME** (Type) ASHBY W. SMITH

**22d. ADDRESS** 13018 Georgia Ave., Wheaton, Md.

**23a. BURIAL, CREMATION, REMOVAL** (Specify): Burial-transit

**23b. DATE THEREOF**: 3-17-62

**23c. NAME OF CEMETERY OR CREMATORY**: Mt. View Cemetery

**23d. LOCATION** (City, town or county): Reno, (State) Nevada

**24 FUNERAL DIRECTOR'S SIGNATURE**: ROBERT A. PUMPHREY

ADDRESS: Bethesda, Md.

**25a. REC'D BY REGISTRAR** DATE: MAR 20 '62

**25b. REGISTRAR'S SIGNATURE**: Arthur S. Hirsch

**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 1 should be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR ATS (4)
15M 7/61

# MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

03481 **CERTIFICATE OF DEATH** 03474

1. PLACE OF DEATH a. COUNTY: Montgomery MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 15 years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 4700 Locust Hill Circle

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE: Maryland b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
d. STREET ADDRESS: 4700 Locust Hill Circle
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First INEZ Middle Last MAYHEW
4. DATE OF DEATH: Month March Day 23, Year 19 62
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Oct. 11, 1874
9. AGE (In years last birthday): 87 yrs. IF UNDER 1 YEAR: Months 5 Days 12 IF UNDER 24 HRS.: Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Barnesville, Ohio
12. CITIZEN OF WHAT COUNTRY? U. S.
13. FATHER'S NAME: James Price
14. MOTHER'S MAIDEN NAME: Mary Connor
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Daughter Address: Mrs. Helen M. Lee Same as Item 2.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure — 1 week
DUE TO (b) Arteriosclerotic Heart Disease — 7 Years
DUE TO (c) Generalized Arteriosclerosis — 10 Years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Bronchiectasis, chronic
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from DEC. 30 1954 to MAR. 23 1962 that (I) (we) last saw the deceased alive on March 17 1962, and that death occurred at 12:15 A.M. from the causes and on the date stated above

22a. SIGNATURE: Robert A. Angle, M.D. M.D.
ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED: 3/23/62
22c. PHYSICIAN'S NAME (Type): ROBERT A. ANGLE
22d. ADDRESS: 5009 Del Ray Ave, Bethesda, Md.

23a. BURIAL CREMATION REMOVAL (Specify): Burial-transit
23b. DATE THEREOF: 3-23-62
23c. NAME OF CEMETERY OR CREMATORY: Dorset Cemetery
23d. LOCATION (City, town, or county) (State): Dorset, Ohio

24. FUNERAL DIRECTOR'S SIGNATURE: ROBERT A. PUMPHREY ADDRESS: Bethesda, Md.
25a. REC'D BY REGISTRAR DATE MAR 27 '62
25b. REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL [illegible]ENDING PHYSICIAN: The law requires that the death certificate be executed within 24 ho[illegible]ter death. Page 4 may be retai[illegible] hospital or attending physician.
TO FUNERAL DIRECTOR: After th s certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State [illegible]oard of H[illegible]lth prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03482

# CERTIFICATE OF DEATH

03475

1. PLACE OF DEATH
a. COUNTY: Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
MARYLAND
c. LENGTH OF STAY IN this place: 28 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): The Clinical Center, Bethesda 14, Md.

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Kentucky
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Frankfort,
d. STREET ADDRESS: Route # 4
e. IS RESIDENCE ON A FARM? YES [ ] NO [X]

3. NAME OF DECEASED (Type or print): First: Kenneth; Middle: Allen; Last: McDaniel

4. DATE OF DEATH: Month: March; Day: 27; Year: 1962

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH: 9 May 1934

9. AGE (In years last birthday): 27 yrs. IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hours: Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Plumber Helper

10b. KIND OF BUSINESS OR INDUSTRY: Plumbing

11. BIRTHPLACE (County & State, or foreign country): Kentucky

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Nathan McDaniel

14. MOTHER'S MAIDEN NAME: Eliza Cotton

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)

16. SOCIAL SECURITY NO.: 404-38-8449

17. INFORMANT: The Medical Record, Address: The Clinical Center, Bethesda 14, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Embolus, pulmonary artery — INTERVAL BETWEEN ONSET AND DEATH: Terminal
DUE TO
(b) Congestive heart failure — months
DUE TO
(c) Congenital heart disease, Corrected transposition of Great vessels with mitral insufficiency — 27 years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

7347

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES [X] NO [ ]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED: While at work [ ] Not While at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Feb. 27, 1962 to March 27, 1962, that (I) (we) last saw the deceased alive on March 27, 1962, and that death occured at 3 p.M, from the causes and on the date stated above.

22a. SIGNATURE: James R. Carter Jr. M.D

22b. DATE SIGNED: 3/28/62

ATTENDING PHYS. [ ] MED. DIRECTOR [ ] STAFF PHYS. [X]

22c. PHYSICIAN'S NAME (Type): James R. Carter, Jr., M.D.

22d. ADDRESS: The Clinical Center, National Institutes of Health, Bethesda 14, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial-transit

23b. DATE THEREOF: 3-28-62

23c. NAME OF CEMETERY OR CREMATORY: Sunset Memorial Gardens

23d. LOCATION (City, town or county) (State): Woodford County, Ky.

24 FUNERAL DIRECTOR'S SIGNATURE: ROBERT A. PUMPHREY

ADDRESS: Bethesda, Md.

25a. REC'D BY REGISTRAR DATE: MAR 30 '62

25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed in 24 hours after death. Page 1 should be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03493 **CERTIFICATE OF DEATH** 03476

1 M

**1. PLACE OF DEATH**
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 1 hr. 35 min.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Suburban

**2. USUAL RESIDENCE** (Where deceased lived. If Institution: Residence before admission)
a. STATE: Md.
b. COUNTY: Mont. Co.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
d. STREET ADDRESS: 8009 - Piney Branch Rd.
IS RESIDENCE ON A FARM? YES ☐ NO ☒

**3. NAME OF DECEASED** (Type or print): First: Willard; Middle: L.; Last: McDaniel

**4. DATE OF DEATH**: Month: March; Day: 2; Year: 1962

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 12/31/01
9. AGE (In years last birthday): 60 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Salesman
10b. KIND OF BUSINESS OR INDUSTRY: Automobiles
11. BIRTHPLACE (County & State, or foreign country): Ohio
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Wesley McDaniel
14. MOTHER'S MAIDEN NAME: Clara Queen

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
16. SOCIAL SECURITY NO.: No
17. INFORMANT: Bernice McDaniel — Address: Same

I

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Posterior myocardial infarction, acute
DUE TO (b) ASHD
DUE TO (c) Peripheral vascular collapse

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: 3 Hours

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I.a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) ☐
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Mar. 2, 1962 to Mar. 2, 1962 that (I) (we) last saw the deceased alive on Mar. 2 1962 and that death occured at 8:50 PM from the causes and on the date stated above.

22a. SIGNATURE: Philip R. Farmer — M.D. — ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type)
22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify): Cremation
23b. DATE THEREOF: 3-6-62
23c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Cemetery
23d. LOCATION (City, town or county): Suitland — (State): Maryland

24. FUNERAL DIRECTOR'S SIGNATURE: Deal Funeral Home — ADDRESS: 4812 - Geo. ave.
25a. RECEIVED BY REGISTRAR — DATE: MAR 8 '62
25b. REGISTRAR'S SIGNATURE: Carlton S. Evans

**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 1 must be retained by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03484 **CERTIFICATE OF DEATH** 03477

Item 14 A.M. G,10 4/9 02 1wk

1. PLACE OF DEATH
a. COUNTY: Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda (Rural)
c. LENGTH OF STAY IN 1b: 3 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): U. S. Naval Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
d. STREET ADDRESS: 705 Alvin Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Keith; Middle: Brian; Last: Mc Grath

4. DATE OF DEATH: Month: MARCH; Day: 30; Year: 1962

5. SEX: Male
6. COLOR OR RACE: Caucasian
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: June 8,1961
9. AGE (In years last birthday): yrs; IF UNDER 1 YEAR: Months 9, Days; IF UNDER 24 HRS.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Child
10b. KIND OF BUSINESS OR INDUSTRY: ----------
11. BIRTHPLACE (County & State, or foreign country): Montana
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Kenneth Mazick Mc Grath
14. MOTHER'S MAIDEN NAME: Myrna Campbell
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
(If yes give war or dates of service): ----------
16. SOCIAL SECURITY NO.:
17. INFORMANT: Hospital Records Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 3312 HEMORRHAGE, CEREBRAL — INTERVAL BETWEEN ONSET AND DEATH: 3 DAYS

331X

DUE TO (b)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from March 28, 1962, to March 30, 1962, that (I) (we) last saw the deceased alive on March 30 19.62, and that death occured at 4:32PM from the causes and on the date stated above.

22a. SIGNATURE: Lewis P. Scott
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type): Lewis P. Scott LCDR MC USN
M.D. ☐ ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS ☐
22d. ADDRESS: U. S. Naval Hospital, Bethesda, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 4-1-62
23c. NAME OF CEMETERY OR CREMATORY: Parsons
23d. LOCATION (City, town or county) (State): Salisbury, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE: Norman T. Baker
ADDRESS: Hill & Johnson Co. 705 E. Main St. Salisbury, Md.

25a. REC'D BY REGISTRAR DATE APR 3 '62
25b. REGISTRAR'S SIGNATURE: Clarence S. Hume

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be exe[illegible] within 24 hours after death. Page 1 should be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
15M 7/61

1163

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03485

## CERTIFICATE OF DEATH

03478

**1. PLACE OF DEATH**
a. COUNTY: Montgomery ~~Kensington Gardens Sanatorium~~ MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Kensington
c. LENGTH OF STAY IN 1b: 21 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Kensington Gardens Sanatorium

**2. USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
a. STATE: VIRGINIA
b. COUNTY: NORFOLK
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): PORTSMOUTH
d. STREET ADDRESS: 1810 PRENTIS AVE ~~3000 Wisconsin Ave Kensington Md~~
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

**3. NAME OF DECEASED** (Type or print): First: Delia; Middle: F; Last: McHorney

**4. DATE OF DEATH**: Month: 3; Day: 18; Year: 1962

**5. SEX**: F

**6. COLOR OR RACE**: W

**7. MARRIED** ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

**8. DATE OF BIRTH**: Dec 18 1870

**9. AGE** (In years last birthday): 91 yrs. IF UNDER 1 YEAR: Months / Days; IF UNDER 24 HRS.: Hours / Min.

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): Housewife

**10b. KIND OF BUSINESS OR INDUSTRY**: Own home

**11. BIRTHPLACE** (County & State, or foreign country): ~~Va~~ Virginia

**12. CITIZEN OF WHAT COUNTRY?**: U.S.A.

**13. FATHER'S NAME**: Benjamin Lukefundie II

**14. MOTHER'S MAIDEN NAME**: Frances Coleman

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unknown): No (If yes give were or dates of service): None

**16. SOCIAL SECURITY NO.**: None

**17. INFORMANT**: George McHorney 9119 Bradford Rd, S.S., Md.

**18. CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 2 days
DUE TO (b): Congestive Heart failure — 2 mos
DUE TO (c): Arteriosclerotic Heart Disease — 5 yrs

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): 

**19. WAS AUTOPSY PERFORMED?** YES ☐ NO ☑

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 1-1, 1961, to 3-18, 1962, that (I) (we) last saw the deceased alive on 3-18, 1962, and that death occured at 11 PM, from the causes and on the date stated above.

22a. SIGNATURE: Donald Nelson M.D.
ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 3/18/62

22c. PHYSICIAN'S NAME (Type): ~~Donad~~ Donald Nelson

22d. ADDRESS: 11,128 Norlee Drive, Silver Spring, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 3-21-62
23c. NAME OF CEMETERY OR CREMATORY: Olive Branch Cemetery
23d. LOCATION (City, town or county) (State): Portsmouth Norfolk Virginia

24 FUNERAL DIRECTOR'S SIGNATURE: Raymond A Fiske ADDRESS: 8434 Georgia Ave
Warner E. Pumphrey, Inc. Silver Spring, Maryland

25a. REC'D BY REGISTRAR DATE: MAR 21 '62
25b. REGISTRAR'S SIGNATURE: Arthur S. Kruse

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed in 24 hours after death. Page 4 should be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

FOR STATE HEALTH DEPT.

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03486 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 03479

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
c. LENGTH OF STAY IN 1b: 20 min.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Chauncey Funeral Home

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Md
b. COUNTY: Mont
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 24 Silver Spring
d. STREET ADDRESS: 13505 Olympia St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Andrew — Middle: Paul — Last: McKay

4. DATE OF DEATH: Month: Mar — Day: 30 — Year: 1962

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Nov 15 1895
9. AGE (In years last birthday): 66 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Supt. - Storage Co. - retired
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): ~~Md~~ D.C.
12. CITIZEN OF WHAT COUNTRY? U.S.C.

13. FATHER'S NAME: ~~Mr~~ William McKay
14. MOTHER'S MAIDEN NAME: Elizabeth Lacy

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Edith M. Stewart — Address: 710 Fifth Ave Silver Spring

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary occlusion
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: Sudden

ICD 201

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Frank J. Broschart M.D
EXAMINER'S NAME (Type): FRANK J. BROSCHART
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county):
DATE SIGNED: 3-30-62

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: April 3-1962
22c. NAME OF CEMETERY OR CREMATORY: Gate of Heaven
22d. LOCATION (City, town, or county): Georgetown Montg Co — (State) Md.

23. FUNERAL DIRECTOR: Arthur Walters — ADDRESS: 254 Farragut St NW
24a. REC'D BY REGISTRAR: DATE APR 3 '62
24b. REGISTRAR'S SIGNATURE: Ciletha M. Pearce

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any is necessary, please execute in duplicate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AISME
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FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03480

**1. PLACE OF DEATH**
a. COUNTY: Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Brookmont
c. LENGTH OF STAY IN 1b: MARYLAND
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Army Map Service 1600 Wilson Blvd

**2. USUAL RESIDENCE** (Where deceased lived. If institutional, last residence before admission)
a. STATE: Va
b. COUNTY: Arlington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Arlington
d. STREET ADDRESS: 1313 N Hudson St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

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3. NAME OF DECEASED (Type or print): First John, Middle Bernard, Last McKnee
4. DATE OF DEATH: Month Mar, Day 14, Year 1962
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 8-28-1907
9. AGE (In years last birthday): 54 yrs. IF UNDER 1 YEAR: Months / Days; IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Lithographer
10b. KIND OF BUSINESS OR INDUSTRY: Army Map Serv.
11. BIRTHPLACE (State or foreign country): DC
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Harry H. McKnee
14. MOTHER'S MAIDEN NAME: Jessie Robertson
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Army Map Service records — Address

**MEDICAL CERTIFICATION**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral hemorrhage + laceration
DUE TO (b): Bullet wound thru skull
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
INTERVAL BETWEEN ONSET AND DEATH: Sudden

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.): Self inflicted bullet wound thru skull — 38 cal.
20c. TIME OF INJURY: Hour 10:20 a.m. Month, Day, Year 3-14 1962
20d. INJURY OCCURRED: While at work ☒ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Army Map Serv
20f. (City or town) Brookmont (County) Monty (State) Md

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐ Accident ☐ Suicide ☒ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Frank J. Broschart M.D
EXAMINER'S NAME (Type): FRANK J. BROSCHART
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county)
DATE SIGNED: 3-14-62

22a. BURIAL, CREMATION, REMOVAL (Specify): burial
22b. DATE THEREOF: March 17, 1962
22c. NAME OF CEMETERY OR CREMATORY: Glenwood
22d. LOCATION (City, town, or country) (State): Washington, D.C.

23. FUNERAL DIRECTOR: Ives Funeral Home, Inc. J. C. Gray
ADDRESS: Arlington, Virginia

24a. REC'D BY REGISTRAR DATE MAR 15 '62
24b. REGISTRAR'S SIGNATURE: Arthur S. Thomas

**TO DEATH MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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# MARYLAND STATE DEPARTMENT OF HEALTH

**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

03488 **CERTIFICATE OF DEATH** 03481

**1. PLACE OF DEATH**
a. COUNTY: MONTGOMERY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BETHESDA
c. LENGTH OF STAY IN 1b: 6 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Suburban

**2. USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: MONTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BETHESDA 14.
d. STREET ADDRESS: 4503 HIGHLAND AVE.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

**3. NAME OF DECEASED** (Type or print): First LESLIE Middle D. Last MEASELL

**4. DATE OF DEATH**: Month MARCH Day 28 Year 1962

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 11/6/21
9. AGE (In years last birthday): 40 yrs. | IF UNDER 1 YEAR: Months, Days | IF UNDER 24 HRS: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Salesman
10b. KIND OF BUSINESS OR INDUSTRY: Real Estate
11. BIRTHPLACE (County & State, or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.A
13. FATHER'S NAME: Leslie D. Measell SR.
14. MOTHER'S MAIDEN NAME: Fannie Reynolds
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): Yes (If yes give war or dates of service): Army
16. SOCIAL SECURITY NO: 577-28-9347
17. INFORMANT: Wife Jean K. Measell Same as above Address

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinoma liver - metastatic
DUE TO (b): CARCINOMA, Stomach
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
143X

INTERVAL BETWEEN ONSET AND DEATH: 2y

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (~~this hospital~~) attended the deceased from Oct. 19 55, to Mar. 28 1962, that (I) (we) last saw the deceased alive on 3-28 1962, and that death occured at 7.35 A M, from the causes and on the date stated above.

22a. SIGNATURE: Alfred S. Norton
22b. DATE SIGNED: 3.28.62
22c. PHYSICIAN'S NAME (Type): Alfred S. Norton, M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22d. ADDRESS: Bethesda Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 4/2/62
23c. NAME OF CEMETERY OR CREMATORY: Arlington Cemetery
23d. LOCATION (City, town or county) (State): Arlington, Virginia

24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Robert A. Pumphrey, Bethesda, Maryland

25a. REC'D BY REGISTRAR DATE APR 2 '62
25b. REGISTRAR'S SIGNATURE

**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 1 should be retained by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

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OUR STATE HEALTH DEPT.

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02489

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03482

**1. PLACE OF DEATH**
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: DOA.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Washington Sanitarium

**2. USUAL RESIDENCE** (Where deceased lived, if institution: Res'dence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
d. STREET ADDRESS: 10111 Brock Dr
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Ida — Middle: (NMN) — Last: Menick
4. DATE OF DEATH: Month: 3 — Day: 7 — Year: 1962

5. SEX: F
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 12-?-89
9. AGE (In years last birthday): 72 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): Russia
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Tievel Kendal
14. MOTHER'S MAIDEN NAME: Dina Rosenberg
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service): —
16. SOCIAL SECURITY NO.: NONE
17. INFORMANT: Mrs Sylvia Resnick — Address: 10119 Brock Dr. SS Md.

**MEDICAL CERTIFICATION**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) ACUTE RIGHT CORONARY OCCLUSION — INTERVAL BETWEEN ONSET AND DEATH: SUDDEN
DUE TO (b) PULMONARY HEMORRHAGE, MASSIVE — SUDDEN
DUE TO (c) BRONCHOPNEUMONIA, ACUTE — DAYS, FEW,

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Frank J. Brosehart M.D.
EXAMINER'S NAME (Type): FRANK J. Brosehart
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county):
DATE SIGNED: 3-8-62

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 3/9/62
22c. NAME OF CEMETERY OR CREMATORY: D.C. Lodge Cem.
22d. LOCATION (City, town, or country): WASH, D.C. (State)

23. FUNERAL DIRECTOR: Hadley Funeral Home
ADDRESS: 4217-9th Ne
24a. REC'D BY REGISTRAR DATE: MAR 12 '62
24b. REGISTRAR'S SIGNATURE: Arthur S. Kruse

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If autopsy is necessary, please execute the certificate, writing the word "pending" in penc'l in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 3 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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# MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

03490

## CERTIFICATE OF DEATH

03483

1. PLACE OF DEATH
a. COUNTY: Montgomery Co. MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Wheaton
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Wheaton Nursing Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 10 Bethesda
d. STREET ADDRESS: 14 North Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Elizabeth Middle: Pawson Last: Mider

4. DATE OF DEATH: Month: Mar. Day: 27, Year: 19 62

5. SEX: Female
6. COLOR OR RACE: Cau.
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: July 8, 1871
9. AGE (In years last birthday): 90 yrs.
IF UNDER 1 YEAR: Months: Days:
IF UNDER 24 HRS: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): England
12. CITIZEN OF WHAT COUNTRY? Naturalized U.S.A.

13. FATHER'S NAME: George Pawson
14. MOTHER'S MAIDEN NAME: Mary Bradley

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Son Kenneth Mider Address: RD #1 Hornell, New York

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CEREBRAL THROMBOSIS — INTERVAL BETWEEN ONSET AND DEATH: 2 DAYS
DUE TO (b) CEREBRAL ARTERIOSCLEROSIS — UNDETERMINED
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 12/26/61, 19, to 3/27, 1962, that (I) (we) last saw the deceased alive on 3/27, 1962, and that death occurred at 3:45 AM from the causes and on the date stated above.

22a. SIGNATURE: John N. Tuohy M.D
ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED: Mar. 27, 1962
22c. PHYSICIAN'S NAME (Type): JOHN N. TUOHY
22d. ADDRESS: 7720 Wisconsin Ave., Bethesda, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 3/30/62
23c. NAME OF CEMETERY OR CREMATORY: Arkport Cemetery
23d. LOCATION (City, town or county) (State): Steuben County, N. Y.

24. FUNERAL DIRECTOR'S SIGNATURE: Robert A. Pumphrey, Bethesda, Maryland
ADDRESS:
25a. REC'D BY REGISTRAR DATE MAR 28 '62
25b. REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03491

## CERTIFICATE OF DEATH

03484

**TO HOLD BURIAL PERMIT ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. (See page 4 of instructions.) It should be retained by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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1. PLACE OF DEATH
a. COUNTY: Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda (Rural)
c. LENGTH OF STAY IN this place: 13 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): U. S. Naval Hospital
MARYLAND

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: North Carolina
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Jacksonville
d. STREET ADDRESS: Howerton Apts. Apt. #7
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

TEX

3. NAME OF DECEASED (Type or print): First: Dale; Middle: Robert; Last: Milks
4. DATE OF DEATH: Month: March; Day: 20; Year: 1962
5. SEX: Male
6. COLOR OR RACE: Caucasian
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: January 28, 1962
9. AGE (In years last birthday) yrs.: IF UNDER 1 YEAR: Months: 1; Days: 20; IF UNDER 24 HRS.: Hours: ; Min.:
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Child
10b. KIND OF BUSINESS OR INDUSTRY: - - - - - -
11. BIRTHPLACE (County & State, or foreign country): Tenn.
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Richard Milks
14. MOTHER'S MAIDEN NAME: Nancy Lawrence
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unkown): No
(If yes give war or dates of service)
16. SOCIAL SECURITY NO.: - - - - -
17. INFORMANT: Hospital Records
Address

E-1

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Meningomyelocele
DUE TO (b) Hydrocephalus
DUE TO (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

2

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that ☒ (this hospital) attended the deceased from March 7, 1962, to March 20, 1962 that (☒ (we) last saw the deceased alive on March 20, 1962 and that death occured at 8:05 PM from the causes and on the date stated above.

22a. SIGNATURE: Frederic Schulaner M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: March 21, 1962
22c. PHYSICIAN'S NAME (Type): Frederic A. Schulaner LT MC USN
22d. ADDRESS: U. S. Naval Hospital, Bethesda, Md.

1

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 3/23/62
23c. NAME OF CEMETERY OR CREMATORY: Arlington National
23d. LOCATION (City, town or county) (State): Arlington, Virginia
24. FUNERAL DIRECTOR'S SIGNATURE: Tyson-Wheeler Funeral Home, Rockville Pike,
ADDRESS: Rockville, Md.
25a. REC'D BY REGISTRAR: DATE MAR 23 '62
25b. REGISTRAR'S SIGNATURE: Arthur S. Kruse

VR A15 (4)
15M 7/61

# MARYLAND STATE DEPARTMENT OF HEALTH

**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

03492 **CERTIFICATE OF DEATH** 03485

**1. PLACE OF DEATH**
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 16 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): The Clinical Center, Bethesda 14, Md.

**2. USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
a. STATE: District of Columbia
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington
d. STREET ADDRESS: 1360 Peabody Street, N.W. Apt 4
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

**3. NAME OF DECEASED** (Type or print): First: Edna — Middle: Lorena — Last: Miller

**4. DATE OF DEATH**: Month: March — Day: 11 — Year: 19 62

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: October 6, 1890
9. AGE (In years last birthday): 71 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (County & State, or foreign country): Illinois
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Levi G. Nutt
14. MOTHER'S MAIDEN NAME: Mary U. Armitage

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No — (If yes give war or dates of service):
16. SOCIAL SECURITY NO: None
17. INFORMANT: "The Medical Record" The Clinical Center, Bethesda 14, Maryland

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Massive gastrointestinal hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 12 hours
DUE TO (b): Acute multiple gastric & duodenal ulcers — 3 days
DUE TO (c): Post op state total pelvic exenteration — 5 days

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

171X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Adenocarcinoma of uterine cervix

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (☒ (this hospital) attended the deceased from February 23, 19 62 to March 11, 19 62, that (☒ (we) last saw the deceased alive on March 11, 19 62, and that death occured at 12:40 PM, from the causes and on the date stated above.

22a SIGNATURE: Yosef H. Pilch, M.D., M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type): Yosef M. Pilch, M.D.
22d ADDRESS: The Clinical Center, National Institutes of Health, Bethesda 14, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): burial
23b. DATE THEREOF: 3/14/62
23c. NAME OF CEMETERY OR CREMATORY: Rock Creek Cemetery
23d. LOCATION (City, town or county) (State): Washington, D.C.

24. FUNERAL DIRECTOR'S SIGNATURE: The S.H.Hines Co.,
ADDRESS: 2901 14th St. N.W., Wash,DC
25a. REC'D BY REGISTRAR DATE MAR 14 '62
25b. REGISTRAR'S SIGNATURE: Arthur S. Hines

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely signed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and, in any event, within 72 hours after death.

VII A15 (4)
15M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

03493 **CERTIFICATE OF DEATH** 03486

**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely executed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda (Rural)
c. LENGTH OF STAY IN 1b: 2 hr. 20 min.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): U. S. Naval Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Springs
d. STREET ADDRESS: 11900 Renick Lane
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Dorthea Middle: Thelma Last: Milne
4. DATE OF DEATH: Month: March Day: 14, Year: 19 62
5. SEX: Female
6. COLOR OR RACE: Caucasian
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: March 14, 1962
9. AGE (In years last birthday) yrs.: IF UNDER 1 YEAR Months: Days: IF UNDER 24 HRS. Hours: 2 Min.: 20
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): - - - - -
10b. KIND OF BUSINESS OR INDUSTRY: - - - - -
11. BIRTHPLACE (County & State, or foreign country): Bethesda, Maryland
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: George G. Milne III
14. MOTHER'S MAIDEN NAME: Virginia Gerhold Poehlman
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No (If yes give war or dates of service): - - - -
16. SOCIAL SECURITY NO.: - - - -
17. INFORMANT: Hospital Records Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Prematurity and Immaturity
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from March 14, 19 62 to March 14, 1962, that (I) (we) last saw the deceased alive on March 14, 1962, and that death occured at 6:30AM from the causes and on the date stated above.

22a. SIGNATURE: Frederic Schulaner M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: March 14, 1962
22c. PHYSICIAN'S NAME (Type): FREDERIC SCHULANER, LT MC USN
22d. ADDRESS: U. S. Naval Hospital, Bethesda, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 3-20-62
23c. NAME OF CEMETERY OR CREMATORY: Arlington National
23d. LOCATION (City, town or county) (State): Arlington, Virginia

24. FUNERAL DIRECTOR'S SIGNATURE: Tyson-Wheeler
ADDRESS: Tyson-Wheeler Funeral Home, Rockville Pike, Rockville, Md.
25a. REC'D BY REGISTRAR DATE: MAR 19 '62
25b. REGISTRAR'S SIGNATURE: Arthur S. Hanna

VR A15 (4)
15M 7.61

# MARYLAND STATE DEPARTMENT OF HEALTH

**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

03495

## CERTIFICATE OF DEATH

Item 2, 10, 11 ... jwk

03488

**1. PLACE OF DEATH**
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda (Rural)
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): U. S. Naval Hospital

**2. USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
a. STATE: Louisiana
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bossier City
d. STREET ADDRESS: 2414 Arlington Place
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

**3. NAME OF DECEASED** (Type or print): First: Joyce — Middle: Leigh — Last: Mitchell

**4. DATE OF DEATH**: Month: March — Day: 14, — Year: 1962

**5. SEX**: Female

**6. COLOR OR RACE**: Caucasian

**7. MARRIED** ☐ **NEVER MARRIED** ☒ **WIDOWED** ☐ **DIVORCED** ☐

**8. DATE OF BIRTH**: Nov. 29, 1961

**9. AGE** (In years last birthday): yrs. — IF UNDER 1 YEAR: Months: 3 — Days: 13 — IF UNDER 24 HRS.: Hours: — Min.:

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): - - - - - -

**10b. KIND OF BUSINESS OR INDUSTRY**: - - - - - -

**11. BIRTHPLACE** (County & State or foreign country): Louisiana

**12. CITIZEN OF WHAT COUNTRY?**: USA

**13. FATHER'S NAME**: Russell A. Mitchell

**14. MOTHER'S MAIDEN NAME**: Nannette Marshall

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unkown): No

**16. SOCIAL SECURITY NO.** (If yes give war or dates of service): - - - - - -

**17. INFORMANT**: Mother: Mrs. Nannette Mitchell, Address: Same as #2

**18. CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Congenital Heart Disease
DUE TO (b): Anomalous Pulmonary Venous Return
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: 3 mo 13 days

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

**19. WAS AUTOPSY PERFORMED?** YES ☒ NO ☐

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (☒ (this hospital) attended the deceased from March 1, 1962, to 14 March, 19.62 that (☒ (we) last saw the deceased alive on March 14, 1962, and that death occured at 2:20 PM from the causes and on the date stated above.

22a. SIGNATURE: M C O'Bannon MD

22b. DATE SIGNED: March 15, 1962

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22c. PHYSICIAN'S NAME (Type): M. C. O'BANNON, LT MC USN

22d. ADDRESS: U. S. Naval Hospital, Bethesda, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Mar. 19, 1962

23c. NAME OF CEMETERY OR CREMATORY: Paries

23d. LOCATION (City, town or county) (State): Paries, Missouri

24 FUNERAL DIRECTOR'S SIGNATURE: Robert A. Pumphrey

ADDRESS: Bethesda, Md.

Robert A. Pumphrey Funeral Home, 7557 Wisc. Ave.

25a. REC'D BY REGISTRAR DATE: MAR 19 '62

25b. REGISTRAR'S SIGNATURE: Arthur L. Krause

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed in 24 hours after death. Page 4 should be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03494

# CERTIFICATE OF DEATH

Items 21 & 22b, F1.m G509 3/13/62 iwk

03487

**1. PLACE OF DEATH**
a. COUNTY: Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 31 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): The Clinical Center, Bethesda 14, Md.

**2. USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
a. STATE: New York
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): New York
d. STREET ADDRESS: 21 East 90th Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

**3. NAME OF DECEASED** (Type or print): First: Ethel; Middle: (No middle name); Last: Mittenthal

**4. DATE OF DEATH**: Month: March; Day: 8; Year: 19 62

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 6 September 1909
9. AGE (In years last birthday): 52 yrs. IF UNDER 1 YEAR: Months / Days; IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Medical Secretary
10b. KIND OF BUSINESS OR INDUSTRY: Medical
11. BIRTHPLACE (County & State, or foreign country): New York
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Benjamin Rogatz
14. MOTHER'S MAIDEN NAME: Rosebelle Alexander
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
16. (If yes give war or dates of service): Not available
17. INFORMANT: The Medical Record, The Clinical Center, Bethesda 14, Maryland

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) | Cardiac arrythmia | 5 minutes |
| DUE TO (b) | Congestive heart failure | 9 minutes |
| DUE TO (c) | Scleroderma | 1 - 2 yrs. |

710.0

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I.

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Feb. 5 1962, to March 8, 1962, that (I) (we) last saw the deceased alive on March 8, 1962, and that death occured at 9:30 A.M., from the causes and on the date stated above.

22a. SIGNATURE: Thomas Vates, M.D.
22b. DATE SIGNED: March 8, 1962
22c. PHYSICIAN'S NAME (Type): Thomas Vates, M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22d. ADDRESS: The Clinical Center, National Institutes of Health, Bethesda 14, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 3-9-62
23c. NAME OF CEMETERY ~~OR CREMATORY~~: Temple Israel, Mt. Hope
23d. LOCATION (City, town or county) (State): Hastings-N.Y.

24. FUNERAL DIRECTOR'S SIGNATURE: B. Dangandy Jr. Asst
ADDRESS: 3501-14th St NW
25a. REC'D BY REGISTRAR: DATE MAR 13 '62
25b. REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed in 24 hours after death. Page 4 is retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

03495 **CERTIFICATE OF DEATH** 03489

1 PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 4 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Suburban

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Mont.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
d. STREET ADDRESS: 138 - Ritchie Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Donald — Middle: Henry — Last: Moore.
4. DATE OF DEATH: Month: March — Day: 26 — Year: 1962

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒
8. DATE OF BIRTH: 8-3-94
9. AGE (In years last birthday): 67 yrs
IF UNDER 1 YEAR: Months — Days; IF UNDER 24 HRS: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10b. KIND OF BUSINESS OR INDUSTRY: Auto mechanic
11. BIRTHPLACE (State or foreign country): Ohio
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Robt. Joseph Moore
14. MOTHER'S MAIDEN NAME: Reynolds, First name--Bertha

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): None
16. SOCIAL SECURITY NO: 145-07-6444
17. INFORMANT: Howard Donald Moore — Address: 4913 40th Place, Hyattsville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Acute heart failure — INTERVAL BETWEEN ONSET AND DEATH: 2 hours

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
DUE TO (b): Chronic Pulmonary Emphysema — 20 years
DUE TO (c): Chronic Pulmonary Fibrosis — 20 years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Month, Day, Year — Hour a. m. p. m. — 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 2/22 1962 to 3/26 1962 that (I) (we) last saw the deceased alive on 3/26 1962, and that death occurred at [illegible] M, from the causes and on the date stated above.

22a. SIGNATURE: John E. Everett M.D.
ATTENDING PHYS. ☒ MED DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 3/26/62
22c. PHYSICIAN'S NAME (Type): JOHN E. EVERETT
22a. ADDRESS: 9400 Conn. Ave. Kensington

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 3-29-62
23c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Cemetery
23d. LOCATION (City, town, or county) (State): Suitland Prince George's Co. Md.

24. FUNERAL DIRECTOR'S SIGNATURE: Raymond R. [illegible]
ADDRESS: 8434 Georgia Ave.
Warner E. Pumphrey, Inc. Silver Spring, Maryland
25a. REC'D BY REGISTRAR DATE: MAR 30 '62
25b. REGISTRAR'S SIGNATURE: Arthur S. [illegible]

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 15M 9/59

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03497

## CERTIFICATE OF DEATH

03490

**1. PLACE OF DEATH**
a. COUNTY: Montgoery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Kingston
c. LENGTH OF STAY IN 1b: MARYLAND
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Carroll Hall Sant.

**2. USUAL RESIDENCE** (Where deceased lived, If institution: Residance before admission)
a. STATE: D.C.
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington
d. STREET ADDRESS: 2744 Branbywine St. N.W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

**3. NAME OF DECEASED** (Type or print): First: LILLIAN Middle: Last: McCRE

**4. DATE OF DEATH**: Month: MARCH Day: 7 Year: 1962

**5. SEX**: Female

**6. COLOR OR RACE**: White

**7. MARRIED** ☐ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☒

**8. DATE OF BIRTH**: Nov.11,1886

**9. AGE** (In years last birthday): 75 yrs.

IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hours: Min.:

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): Ret. Safeway Store

**10b. KIND OF BUSINESS OR INDUSTRY**:

**11. BIRTHPLACE** (County & State, or foreign country): Va.

**12. CITIZEN OF WHAT COUNTRY?**:

**13. FATHER'S NAME**: Samuel M. Lightfoot

**14. MOTHER'S MAIDEN NAME**: Mary A. Nelson

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unkown): No

**16. SOCIAL SECURITY NO.** (If yes give year or dates of service): 578-12-0510

**17. INFORMANT**: Mrs. Darnell Crain Jr. Address: (Same AS 2D.)

**MEDICAL CERTIFICATION**

**18. CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) LOBAR PNEUMONIA
DUE TO (b) ARTERIOSCLEROTIC HEART DISEASE
DUE TO (c) PARALYSIS AGITANS

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): SENILITY

**19. WAS AUTOPSY PERFORMED?** YES ☐ NO ☒

**20a. ACCIDENT WAS UNDERLYING** ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

**20b. DESCRIBE HOW INJURY OCCURED.** (Enter nature of injury in Part I or Part II of item 18.)

**20c. TIME OF INJURY** Hour a.m. p.m. Month, Day, Year 19

**20d. INJURY OCCURRED** While at work ☐ Not While at work ☐

**20e. PLACE OF INJURY** (Home, farm, factory, street, office bldg., etc.)

**20f.** (City or town) (County) (State)

**21. I certify** that (I) (~~this hospital~~) attended the deceased from Oct. 10, 1957 to MARCH 7, 1962 that (I) (~~we~~) last saw the deceased alive on MARCH 7 1962 and that death occured at 9.45 A.M. from the causes and on the date stated above.

**22a. SIGNATURE**: Hermann Lourdeau M.D.

ATTENDING PHYS. ☒ MED DIRECTOR ☐ STAFF PHYS. ☐

**22b. DATE SIGNED**: 3/7/62

**22c. PHYSICIAN'S NAME** (Type):

**22d. ADDRESS**: 5206 Norway CHEVY CHASE, Md.

**23a. BURIAL, CREMATION REMOVAL** (Specify): Burial

**23b. DATE THEREOF**: March 9, 1962

**23c. NAME OF CEMETERY OR CREMATORY**: Cedar Hill

**23d. LOCATION** (City, town or county) (State): Suitland Md.

**24. FUNERAL DIRECTOR'S SIGNATURE**: Lee Funeral Home

ADDRESS: Washington D.C.

**25a. REC'D BY REGISTRAR** DATE MAR 9 '62

**25b. REGISTRAR'S SIGNATURE**: Curtis S. [illegible]

**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be exp[illegible] 24 hours after death. Page 4 [illegible] retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

FOR STATE HEALTH DEPT.

M

I

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03498

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03491

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
c. LENGTH OF STAY IN 1b: 11 yrs
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 105 Sunnyside Rd.

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Md
b. COUNTY: Monty
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
d. STREET ADDRESS: 105 Sunnyside Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First / Middle / Last: Martin Luther Moore

4. DATE OF DEATH: Month: Mar; Day: 25; Year: 1962

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 9-6-1910
9. AGE (In years last birthday): 51 yrs. IF UNDER 1 YEAR: Months / Days; IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Assist to Treas Sec
10b. KIND OF BUSINESS OR INDUSTRY: U.S. Treas
11. BIRTHPLACE (State or foreign country): Mo.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Martin T. Moore
14. MOTHER'S MAIDEN NAME: Jessie Grayson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: ?
17. INFORMANT: Margaret Sullivan Moore (wife) Address: Stem 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral hemorrhage + laceration
DUE TO (b) bullet wound into skull
DUE TO (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: Sudden

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.): Self inflicted bullet wound into skull
20c. TIME OF INJURY: Month, Day, Year: 3-25-1962; Hour: noon a.m. p.m.
20d. INJURY OCCURRED: While at work ☐ Not While at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): home
20f. (City or town): Silver Spring (County): Monty (State): Md

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from. Natural causes ☐, Accident ☐, Suicide ☒, Homicide ☐, Undetermined manner ☐

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

ACTUAL SIGNATURE: Frank J. Broschart M.D.
EXAMINER'S NAME (Type): FRANK J. BROSCHART
Address (Street, city, town, or county):
DATE SIGNED: 3-25-62

22a. BURIAL, CREMATION, REMOVAL (Specify): burial
22b. DATE THEREOF: 3/28/62
22c. NAME OF CEMETERY OR CREMATORY: Glenwood Cemetery
22d. LOCATION (City, town, or country) (State): Washington, D.C.

23. FUNERAL DIRECTOR: The S.H. Hines Company
ADDRESS: 2901 14th St. N.W. Washington 9, D.C.
24a. REC'D BY REGISTRAR DATE: MAR 27 '62
24b. REGISTRAR'S SIGNATURE: Arthur S. Thomas

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any [illegible] necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AISME
5M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

03499 Items 8, 9 & 13 Film 0313 5/17/62 mh 03492

1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Naval Med. Center

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE D.C. b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington D.C.
d. STREET ADDRESS 5420 Connecticut NW
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Middle Last: [illegible] E. MORELAND
4. DATE OF DEATH Month March Day 19 Year 1962

5. SEX Female
6. COLOR OR RACE White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH 1888
9. AGE (In years last birthday) 73 yrs
IF UNDER 1 YEAR: Months Days Hours Min.
IF UNDER 24 HRS

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY Domestic
11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Robert Arthur Taylor
14. MOTHER'S MAIDEN NAME Fannie [illegible] Pyles
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Address Kensington Gardens

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Congestive Heart Failure
DUE TO (b) Arteriosclerotic Heart Disease
DUE TO (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

420.0

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Sep 1961 to Mar 19 1962 that (I) (we) last saw the deceased alive on Mar 19 1962 and that death occurred at 8:30 a.m. p.m. from the causes and on the date stated above.

22a. SIGNATURE R. Thibadeau M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type) ROBERT T. THIBADEAU, M.D.
22d. ADDRESS 10609 Concord St. Kensington, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial March 22-62
23b. DATE THEREOF
23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery
23d. LOCATION (City, town, or county) (State) Suitland Maryland

24. FUNERAL DIRECTOR'S SIGNATURE Simmons Bros
ADDRESS 1661-3rd Hope Rd S.E. Wash D.C.
25a. REC'D BY REGISTRAR DATE MAR 21 '62
25b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 15M 9/59

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03508

## CERTIFICATE OF DEATH

03493

Item 2 Film 6311 4/17/62 rph

**1. PLACE OF DEATH**
a. COUNTY: Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Olney, Md.
c. LENGTH OF STAY IN 1b: 3 yrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Brooke Grove Foundation

**2. USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
a. STATE: Md.
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
d. STREET ADDRESS: 10131 Dallas Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

**3. NAME OF DECEASED** (Type or print): First: Christiana; Middle: Margaretta; Last: Neil

**4. DATE OF DEATH**: Month: March; Day: 2; Year: 1962

5. SEX: F
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: July 18, 1869
9. AGE (In years last birthday): 92 yrs. IF UNDER 1 YEAR: Months / Days; IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (County & State, or foreign country): Shelby Co. Ill.
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME: George Christian Aichele
14. MOTHER'S MAIDEN NAME: Christiana Margaretta Metzger
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes give wars or dates of service):
16. SOCIAL SECURITY NO.: Unknown
17. INFORMANT (Address): Brooke Grove Foundation - Olney, Md.

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 3 days

DUE TO (b): Cerebrovascular Accident — 2 mo

DUE TO (c): Hypertensive C V Disease — yrs

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 1959 19..., to 3/2 19 62, that (I) (we) last saw the deceased alive on 2/28 1962, and that death occured at 7:45 A.M. from the causes and on the date stated above.

22a. SIGNATURE: C. H. Johnson
22b. DATE SIGNED: 3/2/62
22c. PHYSICIAN'S NAME (Type): C. H. Johnson
M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22d. ADDRESS: Sandy Spring, Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE THEREOF: 3-2-62
23c. NAME OF CEMETERY OR CREMATORY: Round Hill
23d. LOCATION (City, town or county) (State): Traphill, North Carolina

24. FUNERAL DIRECTOR'S SIGNATURE: Francis H. Barber
ADDRESS: Laytonsville, Md.

25a. REC'D BY REGISTRAR: DATE MAR 6 '62
25b. REGISTRAR'S SIGNATURE: [illegible]

**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed in 24 hours after death. Page 4 should be retained by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
15M 7,61

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03501 **CERTIFICATE OF DEATH** 03494

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 8 hrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Suburban Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Kensington
d. STREET ADDRESS: 3210 Blueford Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Claire — Middle: H. — Last: Nochera

4. DATE OF DEATH: Month: March — Day: 3, — Year: 19 62

5. SEX: Female
6. COLOR OR RACE: white
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 12/10/98
9. AGE (In years last birthday): 63 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Registered Nurse
10b. KIND OF BUSINESS OR INDUSTRY: Nursing
11. BIRTHPLACE (County & State, or foreign country): Pennsylvania
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Thomas Hughes
14. MOTHER'S MAIDEN NAME: Mary Rose Gunning

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): no.
16. SOCIAL SECURITY NO.: Yes Unknown
17. INFORMANT: (Son) Thomas Hughes - same above — Address: same above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Ruptured Aortic Aneurysm — INTERVAL BETWEEN ONSET AND DEATH: 24 hr
DUE TO (b): Arteriosclerosis
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from MAR. 3 1962 to MAR. 3 1962 that (I) (we) last saw the deceased alive on MAR. 3 1962 and that death occured at 8:20 A.M. from the causes and on the date stated above.

22a. SIGNATURE: Robert G. Angle M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: 3/3/62
22c. PHYSICIAN'S NAME (Type): Robert G. Angle
22d. ADDRESS: Bethesda, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 3/6/62
23c. NAME OF CEMETERY OR CREMATORY: Gate of Heaven Cem.
23d. LOCATION (City, town or county) (State): Silver Spring, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE: Robert A. Pumphrey — ADDRESS: Bethesda, Maryland
25a. REC'D BY REGISTRAR DATE: MAR 7 '62
25b. REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VII A15 (4)
15M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

03502 **CERTIFICATE OF DEATH** 03495

1 PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Kensington
c. LENGTH OF STAY IN 1b: 2yrs 3mo.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Kensington Gardens Sanitarium

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: MONTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SILVER SPRING
d. STREET ADDRESS: 916 GIST AVE.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First John Middle Henry Last Nolte
4 DATE OF DEATH: Month March Day 28 Year 1962

5 SEX: Male
6 COLOR OR RACE: WHITE
7 MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8 DATE OF BIRTH: Aug. 3, 1896
9. AGE (In years last birthday): 65 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Plumber
10b. KIND OF BUSINESS OR INDUSTRY: CONTRACTOR
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: HENRY NOLTE
14. MOTHER'S MAIDEN NAME: ELIZABETH BLADMAN

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service): NONE
16. SOCIAL SECURITY NO: UNKNOWN
17. INFORMANT: HELEN R. HAUGH (SISTER) Address: 916 GIST AVE. SILVER SPRING MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 5 days
DUE TO (b): Bronchial asthma — 2-3 yrs.
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
24-1X
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): ~~Acute~~ Encephalomalacia (old strokes)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY: Month, Day, Year; Hour a.m. p.m. 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 3/24, 1962 to 3/28, 1962 that (I) (we) last saw the deceased alive on 3/27, 1962 and that death occurred at 8 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Marvin Wadler M.D.
ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type): MARVIN WADLER
22d. ADDRESS: 8218 Wis. Av. Bet., Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 3/31/62
23c. NAME OF CEMETERY OR CREMATORY: ST. JOHNS
23d. LOCATION (City, town, or county) (State): FOREST GLEN MD.

24. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: W. W. Chambers Co. WASHINGTON D.C.
25a. REC'D BY REGISTRAR: DATE MAR 30 '62
25b. REGISTRAR'S SIGNATURE: [illegible]

**TO HOSPITAL PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
35M 9/59

# MARYLAND STATE DEPARTMENT OF HEALTH

**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

03503 **CERTIFICATE OF DEATH** 03496

**1. PLACE OF DEATH**
a. COUNTY: MONTGOMERY MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): OLNEY
c. LENGTH OF STAY IN 1b: 8hrs. 10 min
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Montgomery General Hospital

**2. USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: MONTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring, X
d. STREET ADDRESS: 1012 Henderson Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: BABY BOY Middle: Last: OWEN
4. DATE OF DEATH: Month 3 Day 17 Year 1962
5. SEX: Male
6. COLOR OR RACE: white
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 3-17-62
9. AGE (In years last birthday): yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours 8 Min. 10
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): new born infant
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Montgomery, Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: William Richard Owen
14. MOTHER'S MAIDEN NAME: Helen Kidwell
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT: hospital records Address

**18. CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Atelectasis — INTERVAL BETWEEN ONSET AND DEATH: At birth

DUE TO (b) Pulmonary Edema

DUE TO (c) Bilateral Adrenal Cortical Atrophy

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 3-17, 1962 to 3-17, 1962 that (I) (we) last saw the deceased alive on 3-17 1962, and that death occured at 8:00 A.M. from the causes and on the date stated above.

22a. SIGNATURE: Jack Schumacher M.D.
22c. PHYSICIAN'S NAME (Type): Jack Schumacher
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22d. ADDRESS: Gaithersburg, Md.
22b. DATE SIGNED: 3-19-62

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 3/21/62
23c. NAME OF CEMETERY OR CREMATORY: Presbyterian Cemetery
23d. LOCATION (City, town or county) (State): Boyds, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE: Tyson Wheeler Funeral Home-1331 N. Montg. Ave. Rockville, Maryland
ADDRESS:
25a. REC'D BY REGISTRAR DATE MAR 22 '62
25b. REGISTRAR'S SIGNATURE: Walter S. Thomas

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed in 24 hours after death. Page 1 should be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 15M 7/61

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03504

## CERTIFICATE OF DEATH

03497

1. PLACE OF DEATH
a. COUNTY: Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: MARYLAND
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): The Clinical Center, Bethesda 14, Md.

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: District Of Columbia
b. COUNTY: ✓
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington
d. STREET ADDRESS: 1914 Connecticut Ave., N.W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Zelma; Middle: Alexandra; Last: Ozols
4. DATE OF DEATH: Month: March; Day: 14; Year: 19 62
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: July 3, 1902
9. AGE (In years last birthday): 59 yrs. IF UNDER 1 YEAR: Months / Days; IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Librarian
10b. KIND OF BUSINESS OR INDUSTRY: Library
11. BIRTHPLACE (County & State or foreign country): Latvia
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Alexander Bergmanis
14. MOTHER'S MAIDEN NAME: Emilie Kavpul
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: 579-42-0889
17. INFORMANT: The Medical Records, The Clinical Center, Bethesda 14, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage into L. Hemithorax — INTERVAL BETWEEN ONSET AND DEATH: 5 days

DUE TO (b) Aplastic anemia — 18 months

DUE TO (c) Multiple myeloma — 18 months

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from September 13, 1961 to March 14, 19 62 that (I) (we) last saw the deceased alive on March 14, 19 62 and that death occured at 8:35 PM, from the causes and on the date stated above.

22a. SIGNATURE: Marvin Lewis M.D.
22b. DATE SIGNED: March 15, 1962
22c. PHYSICIAN'S NAME (Type): Marvin Lewis, M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22d. ADDRESS: The Clinical Center, National Institutes Of Health, Bethesda 14, Md. (State)

23a. BURIAL, ~~CREMATION, REMOVAL (Specify)~~
23b. DATE THEREOF: 3/17/62
23c. NAME OF CEMETERY OR CREMATORY: Rock Creek Cemetery
23d. LOCATION (City, town or county): Washington, D.C.

24 FUNERAL DIRECTOR'S SIGNATURE: The S.H. Hines Co., ADDRESS: 2901 14th St. N.W. Wash, D.C.
25a. REC'D BY REGISTRAR DATE: MAR 19 '62
25b. REGISTRAR'S SIGNATURE: Clifford S. Hines

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

03505 03498

**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed in 24 hours after death. Page 4 should be retained by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda (Rural)
c. LENGTH OF STAY IN this place: 63 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): U. S. Naval Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)
a. STATE: Md. (D. C.)
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington
d. STREET ADDRESS: 5626 Massachusetts Avenue NW
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Wendell; Middle: Anthony; Last: Parker
4. DATE OF DEATH: Month: March; Day: 20; Year: 1962
5. SEX: Male
6. COLOR OR RACE: Caucasian
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: May 10, 1907
9. AGE (In years last birthday): 54 yrs. IF UNDER 1 YEAR: Months / Days; IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired): M.D.
10b. KIND OF BUSINESS OR INDUSTRY: - - - -
11. BIRTHPLACE (County & State, or foreign country): Lakewood, Ohio
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Wendell Parker
14. MOTHER'S MAIDEN NAME: Unknown
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Hospital Records — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma, stomach
DUE TO (b)
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
1 SI X
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I a): Arteriosclerotic Heart Disease

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (X) (this hospital) attended the deceased from Jan. 15, 1962, to March 20, 1962, that (X) (we) last saw the deceased alive on March 20, 1962, and that death occured at 5:45AM from the causes and on the date stated above.

22a. SIGNATURE: John W. Brackett Jr. M.D.
22b. DATE SIGNED: March 20, 1962
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22c. PHYSICIAN'S NAME (Type): JOHN W. BRACKETT JR.
22d. ADDRESS: U. S. Naval Hospital, Bethesda, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 3-23-62
23c. NAME OF CEMETERY OR CREMATORY: Arlington National
23d. LOCATION (City, town or county): Arlington, Virginia (State)

24. FUNERAL DIRECTOR'S SIGNATURE: Robert A. Humphrey
ADDRESS: Bethesda, Md.
Funeral Home, 7557 Wisc. Ave
25a. REC'D BY REGISTRAR DATE MAR 22 '62
25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

VR A15 (4)
15M 7 61

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

03506 — 03499

**1. PLACE OF DEATH**
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN THIS PLACE: 1 day 12 hrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Suburban

**2. USUAL RESIDENCE** (Where deceased lived, if institutional Residence before admission)
a. STATE: Md.
b. COUNTY: Mont.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
d. STREET ADDRESS: 917 - Dale Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First — Elizabeth; Middle — Peterson; Last —
4. DATE OF DEATH: Month — March; Day —; Year — 1962
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 12/2/81
9. AGE (In years last birthday): 80 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Own home
11. BIRTHPLACE (County & State, or foreign country): HARLAN IOWA
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: John O. Michael SON
14. MOTHER'S MAIDEN NAME: MARTINE NELSON
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes give war or dates of service): None
16. SOC. SECURITY NO.: None
17. INFORMANT: Alice P. Berger — Address: 917 Dale Dr, Silver Spring, Md.

**MEDICAL CERTIFICATION**

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Congestive Heart Failure
DUE TO (b) Arteriosclerosis
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Feb. 26, 1962 to Mar. 1, 1962, that (I) (we) last saw the deceased alive on Mar. 1, 1962, and that death occured at 10 A.M. from the causes and on the date stated above.

22a. SIGNATURE: Edward J. Richards M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 3-1-62
22c. PHYSICIAN'S NAME (Type): Edward J. Richards
22d. ADDRESS: 10,110 Georgia Ave, Silver Spring, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 3-5-62
23c. NAME OF CEMETERY OR CREMATORY: Congressional Cemetery
23d. LOCATION (City, town or county) (State): Washington, D.C.

24. FUNERAL DIRECTOR'S SIGNATURE: Raymond A. Fisher
ADDRESS: 8134 Georgia Ave
Warner E. Pumphrey, Inc. Silver Spring, Maryland
25a. REC'D BY REGISTRAR: DATE MAR 5 '62
25b. REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be [illegible] in 24 hours after death. Page 4 [illegible] be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03507 **CERTIFICATE OF DEATH** 03500

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN Ib:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 5605 Albia Road

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 57 Bethesda
d. STREET ADDRESS: 5605 Albia Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: EMILIE — Middle: — Last: PORTO

4. DATE OF DEATH: Month: March — Day: 19, — Year: 19 62

5. SEX: Female — 6. COLOR OR RACE: White — 7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ — 8. DATE OF BIRTH: May 22, 1894 — 9. AGE (In years last birthday): 67 yrs. — IF UNDER 1 YEAR: Months: 9 Days: 27 — IF UNDER 24 HRS: Hours: — Min:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife — 10b. KIND OF BUSINESS OR INDUSTRY: — 11. BIRTHPLACE (County & State, or foreign country): Italy — 12. CITIZEN OF WHAT COUNTRY? USA-Nat.

13. FATHER'S NAME: Albert Musacchio — 14. MOTHER'S MAIDEN NAME: Salmoa Cavalieri

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes give war or dates of service): — 16. SOCIAL SECURITY NO.: None — 17. INFORMANT: Son Joseph B. Porto — Address: Same as Item 2.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: hours

420.1

DUE TO (b): Cardio-Vascular Renal Sclerosis — 10 yrs+

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c): Diabetes Severe — 5 yrs+

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) — 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19 — 20d. INJURY OCCURRED: While at work ☐ Not While at work ☐ — 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Sept. 1960 19....., to March 19, 19 62 that (I) (we) last saw the deceased alive on March 19 1962, and that death occured at 12 noon from the causes and on the date stated above.

22a. SIGNATURE: Dr J. D. Damian M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED: Mar. 19, 1962

22c. PHYSICIAN'S NAME (Type): Jules D. Damian — 22d. ADDRESS: 2741 - 34th St., N.W., Washington, D.C.

23a. BURIAL, CREMATION, REMOVAL (Specify): Entombment — 23b. DATE THEREOF: 3/22/62 — 23c. NAME OF CEMETERY OR CREMATORY: Ft. Lincoln Mousoleum — 23d. LOCATION (City, town or county) (State): Prince George Co. Md.

24. FUNERAL DIRECTOR'S SIGNATURE: Robert A. Pumphrey, Bethesda, Maryland — ADDRESS: — 25a. REC'D BY REGISTRAR: DATE MAR 22 '62 — 25b. REGISTRAR'S SIGNATURE: Arthur L. Krause

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed in 24 hours after death. Page 1 should be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03508

## CERTIFICATE OF DEATH

03501

1. PLACE OF DEATH
a. COUNTY: Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 26 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Suburban Hospital

MARYLAND

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chevy Chase
d. STREET ADDRESS: 6400 Stratford Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First: Erma; Middle: S.; Last: Potts

4. DATE OF DEATH: Month: March; Day: 20; Year: 19 62

5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐
8. DATE OF BIRTH: 6 · 18 · 94
9. AGE (In years last birthday): 67 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSE WIFE
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): WEST VIRGINIA
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: ROBERT SHADE
14. MOTHER'S MAIDEN NAME: VIRGINIA UNGER

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): NO NO
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mrs G.C. Williams Address 12807 Flack St. Silver Spr

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Adenocarcinoma with metastases, primary site undetermined
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH: 3 months

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 2/18/62, 19..., to 3/20/62, 19..., that (I) (we) last saw the deceased alive on March 20, 1962, and that death occured at 4:5 p.M. from the causes and on the date stated above.

22a. SIGNATURE: Robert N. Coale M.D.
22b. DATE SIGNED: March 20, 1962
ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS ☐
22c. PHYSICIAN'S NAME (Type): Dr. Robert N. Coale
22d. ADDRESS: 4429 Bradley Lane, Bethesda.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 3/23/62
23c. NAME OF CEMETERY OR CREMATORY: Mt. Hebron Cemetery
23d. LOCATION (City, town or county) (State): Winchester, Virginia

24. FUNERAL DIRECTOR'S SIGNATURE: Robert A. Pumphrey, Bethesda, Maryland
ADDRESS
25a. REC'D BY REGISTRAR: DATE MAR 27 '62
25b. REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03509 **CERTIFICATE OF DEATH** 03502

**1. PLACE OF DEATH**
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda (Rural)
c. LENGTH OF STAY IN 1b: 199 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): U. S. Naval Hospital

**2. USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
a. STATE: California
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Los Angeles
d. STREET ADDRESS: 1011 1/4 S. Harvard Blvd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Morris — Middle: Edward — Last: Queen
4. DATE OF DEATH: Month: March — Day: 14, — Year: 1962
5. SEX: Male
6. COLOR OR RACE: Negroid
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: May 5, 1937
9. AGE (In years last birthday): 24 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Service Man
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: James H. Queen
14. MOTHER'S MAIDEN NAME: Mary A. Barnes
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): Yes — (If yes give war or dates of service): - - - - - -
16. SOCIAL SECURITY NO.:
17. INFORMANT: Hospital Records — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Granulocytic leukemia
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last — DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (X) (this hospital) attended the deceased from Aug. 27, 1961 to March 14, 1962, that (X) (we) last saw the deceased alive on March 14, 1962, and that death occured at 7:10AM from the causes and on the date stated above.

22a. SIGNATURE: Joseph E. Stitcher M.D.
22b. DATE SIGNED: March 14, 1962
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22c. PHYSICIAN'S NAME (Type): JOSEPH E. STITCHER LCDR MC USN
22d. ADDRESS: U. S. Naval Hospital, Bethesda, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 3-21-62
23c. NAME OF CEMETERY OR CREMATORY: Arlington National
23d. LOCATION (City, town or county) (State): Arlington, Virginia

24. FUNERAL DIRECTOR'S SIGNATURE: James E. Jenkins
JOHNSON & JENKINS FUNERAL HOME, 4804 Ga. Ave. N.W., Washington D.C.
25a. REC'D BY REGISTRAR: DATE MAR 20 '62
25b. REGISTRAR'S SIGNATURE: Ivor L. Kraus

**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A'S (4)
15M 7/61

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

03510 03503

**1. PLACE OF DEATH**
a. COUNTY: Montgomery Co. MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Olney
c. LENGTH OF STAY IN 1b: 27 hrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Montgomery General Hospital

**2. USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rockville
d. STREET ADDRESS: 5910 Ridgway Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

**3. NAME OF DECEASED** (Type or print): First: William James; Middle: ~~Baby Boy~~; Last: Ray

**4. DATE OF DEATH**: Month: Mar.; Day: 3; Year: 19 62

**5. SEX**: male

**6. COLOR OR RACE**: white

**7. MARRIED** ☐ **NEVER MARRIED** ☒ **WIDOWED** ☐ **DIVORCED** ☐

**8. DATE OF BIRTH**: 3/2/62

**9. AGE** (In years last birthday): yrs.; IF UNDER 1 YEAR: Months, Days: 1; IF UNDER 24 HRS.: Hours, Min.

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired):

**10b. KIND OF BUSINESS OR INDUSTRY**:

**11. BIRTHPLACE** (County & State, or foreign country): Montgomery Gen. Hosp.

**12. CITIZEN OF WHAT COUNTRY?**: USA

**13. FATHER'S NAME**: Robert S. Ray

**14. MOTHER'S MAIDEN NAME**: Barbara Tough

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unknown): no
(If yes give war or dates of service):

**16. SOCIAL SECURITY NO.**:

**17. INFORMANT**: Hospital Records Address

**18. CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Atelectasis
DUE TO (b): Congenital Heart Disease
DUE TO (c): Interventricular Septum Defect - Incomplete, rotation of aorta

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Situs Inversus (Complete)

**19. WAS AUTOPSY PERFORMED?** YES ☒ NO ☐

MEDICAL CERTIFICATION

**20a. ACCIDENT WAS UNDERLYING** ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

**20b. DESCRIBE HOW INJURY OCCURED.** (Enter nature of injury in Part I or Part II of item 18.)

**20c. TIME OF INJURY**: Hour a.m. p.m.; Month, Day, Year 19

**20d. INJURY OCCURRED**: While at work ☐ Not While at work ☐

**20e. PLACE OF INJURY** (Home, farm, factory, street, office bldg., etc.):

**20f.** (City or town) (County) (State)

**21. I certify** that (I) (this hospital) attended the deceased from 3/2 19 62 to 3/3 19 62, that (I) (we) last saw the deceased alive on 3/3 19 62, and that death occured at 3:15 P.M., from the causes and on the date stated above.

**22a. SIGNATURE**: C. H. Ligon M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

**22b. DATE SIGNED**: 3/4/62

**22c. PHYSICIAN'S NAME** (Type): Dr. C.H. Ligon

**22d. ADDRESS**: Sandy Spring, Md.

**23a. BURIAL, CREMATION, REMOVAL** (Specify): Burial

**23b. DATE THEREOF**: 3/6/62

**23c. NAME OF CEMETERY OR CREMATORY**: Parklawn

**23d. LOCATION** (City, town or county) (State): Rockville, Maryland

**24. FUNERAL DIRECTOR'S SIGNATURE** ADDRESS: Tyson Wheeler Funeral Home-1331 E. Montg. Ave. Rockville, Maryland

**25a. REC'D BY REGISTRAR** DATE MAR 8 '62

**25b. REGISTRAR'S SIGNATURE**: Arthur L. Thomas

**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

# MARYLAND STATE DEPARTMENT OF HEALTH

**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

## CERTIFICATE OF DEATH

03511 — 03504

**1. PLACE OF DEATH**
a. COUNTY: Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 6 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): The Clinical Center, Bethesda 14, Md.

**2. USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
d. STREET ADDRESS: 607 Dartmouth Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

**3. NAME OF DECEASED** (Type or print): First: James — Middle: Gordon — Last: Reidinger

**4. DATE OF DEATH**: Month: March — Day: 27, — Year: 19 62

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: November 23, 1919
9. AGE (In years at last birthday): 42 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Superintendant
10b. KIND OF BUSINESS OR INDUSTRY: Northwood HighSchool Maintenance
11. BIRTHPLACE (County & State or foreign country): Anniston,Alabama
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Gordon M. Reidinger
14. MOTHER'S MAIDEN NAME: Saidie ~~Sadie~~ Scheid
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service): None
16. SOCIAL SECURITY NO.: 423-07-0122 ~~-Unavailable-~~
17. INFORMANT: The Medical Record — The Clinical Center, Bethesda 14, Maryland

**MEDICAL CERTIFICATION**

**18. CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute pulmonary edema — INTERVAL BETWEEN ONSET AND DEATH: 24 hours
DUE TO (b) Congestive Heart fai[redacted] — Undetermined
DUE TO (c) Chronic Glomerulonephritis[redacted] — Undetermined

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from March 21, 19 62 to March 27, 19 62 that (I) (we) last saw the deceased alive on March 27, 19 62, and that death occured at 5:20 A.M. from the causes and on the date stated above.

22a. SIGNATURE: Norman H. Bell M.D. — MD
ATTENDING PHYS. ☐ MED DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: March 27, 1962
22c. PHYSICIAN'S NAME (Type): Norman H. Bell, M.D.
22d. ADDRESS: The Clinical Center, National Institutes of Health, Bethesda 14, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 3-29-62
23c. NAME OF CEMETERY OR CREMATORY: Highland Cemetery
23d. LOCATION (City, town or county) (State): Anniston Calhoun Co, Alabama

24. FUNERAL DIRECTOR'S SIGNATURE: Raymond A. Zieber — ADDRESS: 8434 Georgia Ave
Warner E. Pumphrey, Inc. Silver Spring, Maryland
25a. REC'D BY REGISTRAR DATE: MAR 29 '62
25b. REGISTRAR'S SIGNATURE: [illegible]

TO PHYSICIAN ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 must be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/60

[redacted]

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

03512 **CERTIFICATE OF DEATH** 03505

1 PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 34y. 10 mos 24dy
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Congressional Manor Sanitarium

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Md.
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rockville
d. STREET ADDRESS: 128 South Adams Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Elizabeth; Middle: ; Last: Rice

4. DATE OF DEATH: Month: MAR; Day: 14; Year: 1962

5. SEX: F
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Oct. 18 1869
9. AGE (In years last birthday): 92 yrs.
IF UNDER 1 YEAR: Months: ; Days: ; IF UNDER 24 HRS: Hours: ; Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Music Teacher
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: George R. Rice
14. MOTHER'S MAIDEN NAME: Alberta Tschiffely

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Julia M. Walter-Neice-Wash. D. C. Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 2 days
DUE TO (b): Generalized d. cerebral arteriosclerosis — 10+ years
DUE TO (c):

34X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Arteriosclerotic heart disease
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Month, Day, Year; Hour a. m. p. m. 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I **certify** that (I) (this hospital) attended the deceased from April 4, 1958, to March 14, 1962, that (I) (we) last saw the deceased alive on March 7, 1962, and that death occurred at 1:30 P.M., from the causes and on the date stated above.

22a. SIGNATURE: G. Bowditch Hunter, Jr. M.D.
ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED: Mar. 14, 1962
22c. PHYSICIAN'S NAME (Type): G. Bowditch Hunter, Jr., M.D.
22d. ADDRESS: 809 Veirs Mill Rd., Rockville Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 3/16/62
23c. NAME OF CEMETERY OR CREMATORY: Darnestown Cemetery
23d. LOCATION (City, town, or county) (State): Darnestown, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: Robert A. Pumphrey, Bethesda, Maryland
25a. REC'D BY REGISTRAR: DATE MAR 1 '62
25b. REGISTRAR'S SIGNATURE: [illegible]

**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03513 **CERTIFICATE OF DEATH** 03506

Item 23b Film 0310 4/2/62 mb

**1. PLACE OF DEATH** a. COUNTY: Montgomery — MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda

c. LENGTH OF STAY IN 1b: 5 days

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): U.S. Naval Hospital

**2. USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission) a. STATE: Maryland b. COUNTY:

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Adelphi

d. STREET ADDRESS: 10506 Edgemont Dr.

e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

**3. NAME OF DECEASED** (Type or print): First: Stanley Middle: Schreiber Last: Ricker

**4. DATE OF DEATH** Month: March Day: 25 Year: 1962

5. SEX: Male 6. COLOR OR RACE: Caucasian 7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: February 3, 1919

9. AGE (In years last birthday): 43 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Naval Officer

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Washington, D.C.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Robert B. Ricker

14. MOTHER'S MAIDEN NAME: Lena Perry

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): Yes (If yes give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: WIFE: Mrs. Pauline T. Ricker Same as #2 Address

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).] INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hepatic failure

I S 2 . 8

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b) Hemorrhagic Peritonitis

DUE TO (c) Metastatic Carcinoma, Colon 4 yrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from March 21, 1962, to March 25, 1962, that (I) (we) last saw the deceased alive on March 25, 1962, and that death occured at 0650 hrs from the causes and on the date stated above.

22a. SIGNATURE: William P. Baker

22b. DATE SIGNED: March 25, 1962

22c. PHYSICIAN'S NAME (Type): WILLIAM P. BAKER LT MC USN

M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22d. ADDRESS: U.S. Naval Hospital, Bethesda, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: Mar. 28, 1962

23c. NAME OF CEMETERY OR CREMATORY: NATIONAL CEMETARY

23d. LOCATION (City, town or county) (State): ARLINGTON, VA.

24. FUNERAL DIRECTOR'S SIGNATURE: S. H. Hines Co. ADDRESS: 2901 14th St. N.W. W.D.C.

S.H.HINES CO.FUNERAL HOME 2901 14TH ST NW WDC

25a. REC'D BY REGISTRAR DATE: MAR 27 '62

25b. REGISTRAR'S SIGNATURE: Arthur L. Thomas

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be examined within 24 hours after death. Page 1 must be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 15M 7 61

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03514

## CERTIFICATE OF DEATH

Reg. Dist. No. 03507

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): TAKOMA PARK
c. LENGTH OF STAY IN 1b: 17 HOURS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: WASHINGTON SANITARIUM & HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution, usual residence before admission.)
a. STATE: MARYLAND
b. COUNTY: PRINCE GEORGES ~~MONTGOMERY~~
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): TAKOMA PARK 1652
d. STREET ADDRESS: 6618 Poplar Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First NELLIE Middle ROSE Last ROBERTSON
4. DATE OF DEATH: Month 3 Day 31 Year 19 62
5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 11-25-85
9. AGE (In years last birthday): 76 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): WASHINGTON, D. C.
12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME: Christian Keiner
14. MOTHER'S MAIDEN NAME: Caroline (unknown)
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: -
17. INFORMANT: Kenneth R. Robertson Address 6109 Wilmett Rd. Bethesda, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 1) Coronary Thrombosis — Cardiac Failure — INTERVAL BETWEEN ONSET AND DEATH: 3 days
DUE TO (b) 2) Chronic Coronary Arteriosclerosis — Undetermined
DUE TO (c) 3) Arterial Hypertension

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Osteo-Arthritis
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED White at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Mar 1, 19 62 to Mar 31, 19 62 that I last saw the deceased alive on Mar 31, 19 62, and that death occurred at 2:10 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Henry L. Ball M.D. ADDRESS (Street, City or town, state): 10620 Georgia Ave DATE SIGNED: Mar 31, 1962
PHYSICIAN'S NAME (Type): George L. Ball Silver Spring Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 4-3-1962
22c. NAME OF CEMETERY OR CREMATORY: Cedar Hill
22d. LOCATION (City, town, or county) (State): Suitland, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Francis J. Collins ADDRESS: 3821-14th St NW Wash. D. C.
24a. REC'D BY REGISTRAR DATE APR 4 '62
24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used for the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03515 **CERTIFICATE OF DEATH** 03508

**1. PLACE OF DEATH**
a. COUNTY: Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Olney
c. LENGTH OF STAY IN 1b: 1 week
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Montgomery General Hospital

**2. USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Gaithersburg
d. STREET ADDRESS: RFD # 1, Box 193B
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

**3. NAME OF DECEASED** (Type or print): First: Charles Middle: Augustus Last: Robinson

**4. DATE OF DEATH** Month: March Day: 5 Year: 1962

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Nov. 17, 1882
9. AGE (In years last birthday): 79 yrs. IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Architect
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Salamanaca, N.Y.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: George Henry Robinson
14. MOTHER'S MAIDEN NAME: Jessie Crocker

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: 276-16-5311
17. INFORMANT: Miss Alice L. Robinson, Address: Item 2

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Terminal Lobular Pneumonia, bilateral — INTERVAL BETWEEN ONSET AND DEATH: 1 week.
DUE TO (b) Advanced cerebral arteriosclerosis with multiple thrombi and endephalomalacia — 5 years
DUE TO (c) Severe arteriosclerotic cardio-vascular-renal disease.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c): Diabetes Mellitus

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.): No injury
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) ~~(this hospital)~~ attended the deceased from 1954, 19..., to March 5, 1962, that (I) ~~(we)~~ last saw the deceased alive on March 5, 1962, and that death occured at 5:20AM, from the causes and on the date stated above.

22a. SIGNATURE: M. McKendree Boyer M.D.
22b. DATE SIGNED: 3/5/62
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22c. PHYSICIAN'S NAME (Type): M. McKendree Boyer, M. D.
22d. ADDRESS: 9830 Main Street Damascus, Maryland.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 3/8/62
23c. NAME OF CEMETERY OR CREMATORY: Acacia Park Cemetery
23d. LOCATION (City, town or county) (State): Mayfield Heights, Ohio.

24 FUNERAL DIRECTOR'S SIGNATURE: Olin L. Mobarnth
ADDRESS: Damascus, Md.
25a. REC'D BY REGISTRAR DATE MAR 7 '62
25b. REGISTRAR'S SIGNATURE: C. Chas. S. Krauss

**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 is retained by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any [illegible] is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03516 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 03509

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 27 hrs 5 mins X
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Suburban

2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)
a. STATE: Md.
b. COUNTY: Mont. Co.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Kensington
d. STREET ADDRESS: 11107- Newport Mill Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Carme la — Middle: Motta — Last: Romeo

4. DATE OF DEATH: Month: March — Day: 16 — Year: 19 62

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 4/9/1900
9. AGE (In years last birthday): 61 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): CATANIA ITALY
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: ANTONIA MOTTA
14. MOTHER'S MAIDEN NAME: GRAZIA CHITE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): —
(If yes give war or dates of service): —
16. SOCIAL SECURITY NO.:
17. INFORMANT: Joe Romeo. Address: 11107 Newport Mill Rd.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Pulmonary embolism — INTERVAL BETWEEN ONSET AND DEATH: sudden
DUE TO (b): Multiple fracture
DUE TO (c): Ran over by auto — 1 day

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I a:

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.): Pedestrian - Ran over by car
20c. TIME OF INJURY: Hour 12:55 p.m. — Month, Day, Year: 3-15 1962
20d. INJURY OCCURRED: While at work ☐ Not While at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): driveway
20f. (City or town): Kensington — (County): Monty — (State): Md

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from. Natural causes ☐. Accident ☒. Suicide ☐. Homicide ☐. Undetermined manner ☐

ACTUAL SIGNATURE: Frank J. Broschart M.D.
EXAMINER'S NAME (Type): FRANK J. BROSCHART
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county):
DATE SIGNED: Mar 17, 1962

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 20 MAR 1962
22c. NAME OF CEMETERY OR CREMATORY: H. Lincoln Mausoleum
22d. LOCATION (City, town, or country): PR Geo Cty (State): Md.

23. FUNERAL DIRECTOR: Rinaldi Funeral Home
ADDRESS: 7400 Georgia Ave NW Wash D.C.

24a. REC'D BY REGISTRAR: DATE MAR 21 '62
24b. REGISTRAR'S SIGNATURE: [illegible]

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03517 **CERTIFICATE OF DEATH** 03510

1. PLACE OF DEATH
a. COUNTY: Montgomery
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: MARYLAND
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Suburban Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): 48 Bethesda
d. STREET ADDRESS: 4806 Middlesex Lane
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Alfio; Middle: Ronsisvalle; Last:
4. DATE OF DEATH: Month: March; Day: 14; Year: 1962
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: May 3, 1888
9. AGE (In years last birthday): 73 yrs. IF UNDER 1 YEAR: Months: 10, Days: 11 IF UNDER 24 HRS.: Hours: , Min.:
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10b. KIND OF BUSINESS OR INDUSTRY: Barbering
11. BIRTHPLACE (County & State, or foreign country): Italy
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Joseph Ronsisvalle
14. MOTHER'S MAIDEN NAME: Concetta Emanuele
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No
16. SOCIAL SECURITY NO.: 577-18-4013
17. INFORMANT: Maria (wife) Address: Same as above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a) (b) and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Generalized Peritonitis — INTERVAL BETWEEN ONSET AND DEATH: 9 days
DUE TO (b): Ruptured Diverticulum, Sigmoid Colon — 9 days
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Mar 4, 1962 to Mar 14, 1962 that (I) (we) last saw the deceased alive on Mar 14, 1962 and that death occured at 8:30 A.M. from the causes and on the date stated above.

22a. SIGNATURE: John P Haberline M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: Mar 14 1962
22c. PHYSICIAN'S NAME (Type): John P. Haberline
22d. ADDRESS: 1015 Spring St Silver Spring Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 3/17/62
23c. NAME OF CEMETERY OR CREMATORY: Gate of Heaven Cem.
23d. LOCATION (City, town or county) (State): Silver Spring, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE / ADDRESS: Robert A. Pumphrey, Bethesda, Maryland
25a. REC'D BY REGISTRAR DATE: MAR 16 '62
25b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

03518 Items 1c, 7 & 14 Film G509 5/29/62 iwk 03511

## CERTIFICATE OF DEATH

**1. PLACE OF DEATH**
a. COUNTY: Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 530 ~~536~~ Days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): The Clinical Center, Bethesda 14, Md.

**2. USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: ~~Baltimore~~
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
d. STREET ADDRESS: 5901 Simmonds Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: David; Middle: N; Last: Rudin
4. DATE OF DEATH: Month: March; Day: 18; Year: 1962
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☒ ~~Divorced~~
8. DATE OF BIRTH: December 3, 1905
9. AGE (In years last birthday): 56 yrs. IF UNDER 1 YEAR: Months, Days IF UNDER 24 HRS.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Physician
10b. KIND OF BUSINESS OR INDUSTRY: Medicine
11. BIRTHPLACE (County & State, or foreign country): Russia
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Nisson Rudin
14. MOTHER'S MAIDEN NAME: Pauline ~~(Last name unknown)~~ Zeldin
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): YES (If yes give war or dates of service): WW II
16. SOCIAL SECURITY NO.: 448-26-1018
17. INFORMANT: The Medical Records
Address: The Clinical Center, Bethesda 14, Maryland

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** [Enter only one cause per line for (a) (b), and (c).]

PART I. DEATH WAS CAUSED BY:

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | Acute pulmonary infarction | 18 Hours |
| DUE TO (b) | Multiple myeloma | 3 Years |
| DUE TO (c) | | |

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. [Enter nature of injury in Part I or Part II of item 18.]
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from October 4, 1960 to March 18, 1962 that (I) (we) last saw the deceased alive on March 18, 1962, and that death occured at 5:05 PM from the causes and on the date stated above.

22a. SIGNATURE: J. L. Fahey
22b. DATE SIGNED: 3/18/62
22c. PHYSICIAN'S NAME (Type): John L. Fahey M.D.
M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22d. ADDRESS: The Clinical Center, National Institutes Of Health, Bethesda 14, Md.

23a. BURIAL, CREMATION REMOVAL (Specify): Burial
23b. DATE THEREOF: March 19, 1962
23c. NAME OF CEMETERY OR CREMATORY: Beth Tfiloh Cemetery
23d. LOCATION (City, town or county) (State): Baltimore, Maryland

24 FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: SOL LEVINSON & BROS. INC. 6010 Reisterstown Rd.
25a. REC'D BY REGISTRAR DATE: MAR 20 '62
25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be completed within 24 hours after death. Page 4 is retained by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

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# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03519 **CERTIFICATE OF DEATH** 03512

**1. PLACE OF DEATH**
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 3days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Suburban Hospital

**2. USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
d. STREET ADDRESS: 4858 Battery Lane,
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

**3. NAME OF DECEASED** (Type or print): First: James Middle: V. Last: Sammartino

**4. DATE OF DEATH**: Month: March Day: 24th. Year: 1962

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 6/24/89
9. AGE (In years last birthday): 72 yrs. IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10b. KIND OF BUSINESS OR INDUSTRY: Supt.-Air Plane Parts Plant
11. BIRTHPLACE (County & State, or foreign country): Italy
12. CITIZEN OF WHAT COUNTRY? Naturalized U.S.A 50 yrs.
13. FATHER'S NAME: Vincent Sammartino
14. MOTHER'S MAIDEN NAME: Antoinette (Unknown)
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: 103-14-4621
17. INFORMANT: Daughter Address: Mrs. Alberta Linn Same as above.

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure — INTERVAL BETWEEN ONSET AND DEATH: 1 year

DUE TO (b) Coronary Arteriosclerotic Ht. Disease-Myocard. Infarction - 1 year

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from December, 1960 to March 24, 1962 that (I) (~~we~~) last saw the deceased alive on March 24. 1962, and that death occured at 9:40 A.M. from the causes and on the date stated above.

22a. SIGNATURE: James W. Egan M.D
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 3-25-62
22c. PHYSICIAN'S NAME (Type): Dr. James W. Egan
22d. ADDRESS: 9911 Old Spring Rd., Kensington, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial-transit
23b. DATE THEREOF: 3-26-62
23c. NAME OF CEMETERY OR CREMATORY: St. Mary's Cemetery
23d. LOCATION (City, town or county) (State): Lawrence, New York

24. FUNERAL DIRECTOR'S SIGNATURE: ROBERT A. PUMPHREY ADDRESS: Bethesda, Md.
25a. REC'D BY REGISTRAR DATE MAR 27 '62
25b. REGISTRAR'S SIGNATURE: Carlton S. Kraus

**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03520 Items 1c, & 2 Fi.m G.W. 3/12/62 **CERTIFICATE OF DEATH** 03513

**1. PLACE OF DEATH**
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rockville
c. LENGTH OF STAY IN 1b: 46 years-3 months
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Chestnut Lodge

**2. USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
a. STATE: ~~Maryland~~ Wash.D.C. — b. COUNTY: ~~Montgomery~~
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ~~Rockville~~, Washington, D.C.
d. STREET ADDRESS: unknown ~~100 N. Montgomery Avenue~~
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

**3. NAME OF DECEASED** (Type or print): First: MARGUERITE — Middle: — Last: SAWYER

**4. DATE OF DEATH**: Month: March — Day: 2 — Year: 1962

**5. SEX**: Female — **6. COLOR OR RACE**: White — **7. MARRIED** ☐ **NEVER MARRIED** ☒ **WIDOWED** ☐ **DIVORCED** ☐

**8. DATE OF BIRTH**: ? 1874

**9. AGE** (In years last birthday): 88 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): None
**10b. KIND OF BUSINESS OR INDUSTRY**:
**11. BIRTHPLACE** (County & State, or foreign country): Unknown
**12. CITIZEN OF WHAT COUNTRY?**: US

**13. FATHER'S NAME**: Lucius Sawyer
**14. MOTHER'S MAIDEN NAME**: Elizabeth M. Ricker

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unkown): No — (If yes give war or dates of service)
**16. SOCIAL SECURITY NO.**: None
**17. INFORMANT**: Hospital Records — Address:

**MEDICAL CERTIFICATION**

**18. CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema — INTERVAL BETWEEN ONSET AND DEATH

450.0 DUE TO (b) Congestive heart failure

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) General arteriosclerosis

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

**19. WAS AUTOPSY PERFORMED?** YES ☐ NO ☒

**20a.** ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
**20b.** DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
**20c.** TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
**20d.** INJURY OCCURRED: While at work ☐ Not While at work ☐
**20e.** PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
**20f.** (City or town) (County) (State)

**21. I certify** that (I) (this hospital) attended the deceased from 7/1/, 1961, to 3/2/, 1962, that (I) (we) last saw the deceased alive on 2/21, 1962, and that death occured at 8 P.M, from the causes and on the date stated above.

**22a.** SIGNATURE: Dexter M. Bullard M.D.
**22b.** DATE SIGNED: Mar. 3, 1962
ATTENDING PHYS. ☐ MED. DIRECTOR ☒ STAFF PHYS. ☐
**22c.** PHYSICIAN'S NAME (Type): DEXTER M. BULLARD, M.D.
**22d.** ADDRESS: Falls Rd., Rockville, Maryland.

**23a.** BURIAL, CREMATION, REMOVAL (Specify): Entombment
**23b.** DATE THEREOF: March 7, 1962
**23c.** NAME OF CEMETERY OR CREMATORY: Rock Creek
**23d.** LOCATION (City, town or county) (State): Washington, D.C.

**24.** FUNERAL DIRECTOR'S SIGNATURE: Tyson Wheeler Funeral Home — ADDRESS: 1331 E. Monty. Ave Rockville, Maryland
**25a.** REC'D BY REGISTRAR: DATE MAR 8 '62
**25b.** REGISTRAR'S SIGNATURE: Charles S. Kraus

**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 7/61

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03531

## CERTIFICATE OF DEATH

03514

1. PLACE OF DEATH
a. COUNTY: Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 4 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): The Clinical Center, Bethesda 14, Md.

2. USUAL RESIDENCE (Where deceased lived. If institutions: Residence before admission)
a. STATE: Illinois
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Peoria
d. STREET ADDRESS: 6918 North Wilshire Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Ralph; Middle: William; Last: Schmitt

4. DATE OF DEATH: March 27, 1962

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: October 15, 1920

9. AGE (In years last birthday): 41 yrs. IF UNDER 1 YEAR: Months / Days; IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter

10b. KIND OF BUSINESS OR INDUSTRY: Contractor

11. BIRTHPLACE (County & State, or foreign country): Illinois

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Henry Aaron Schmitt

14. MOTHER'S MAIDEN NAME: Jennie Decker

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): WW II

16. SOCIAL SECURITY NO: 329-12-7789

17. INFORMANT: The Medical Records, The Clinical Center, Bethesda 14, Maryland

### MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY:

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | Multiple focal hemorrhages in brain | 4 hours |
| DUE TO | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) | Right pleural effusion, right hemothorax | 2 weeks |
| DUE TO (c) | Acute leukemia with hepatomegaly, splenomegaly | 8 weeks |

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that ☒ (this hospital) attended the deceased from March 23, 1962 to March 27, 1962, that ☒ (we) last saw the deceased alive on March 27, 1962, and that death occured at 8:20PM from the causes and on the date stated above.

22a. SIGNATURE: J. David Heywood M.D.

22b. DATE SIGNED: 3/28/62

ATTENDING PHYS ☐ MED. DIRECTOR ☐ STAFF PHYS ☒

22c. PHYSICIAN'S NAME (Type): J. David Heywood, M.D.

22d. ADDRESS: The Clinical Center, National Institutes Of Health, Bethesda 14, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Transit-Burial

23b. DATE THEREOF: 3/28/62

23c. NAME OF CEMETERY OR CREMATORY: St. Joseph Cemetery

23d. LOCATION (City, town or county) (State): Peoria, Illinois

24. FUNERAL DIRECTOR'S SIGNATURE / ADDRESS: Robert A. Pumphrey, Bethesda, Maryland

25a. REC'D BY REGISTRAR DATE: MAR 30 '62

25b. REGISTRAR'S SIGNATURE: Clifford S. Hines

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15-(4)
15M 9/60

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**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03522 **CERTIFICATE OF DEATH** 03515

1. PLACE OF DEATH
a. COUNTY: Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
c. LENGTH OF STAY IN MARYLAND: lb
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 623-Gist Ave.

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
d. STREET ADDRESS: 623 Gist Avenue
a. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Lottie Middle: Lucetta Last: Schorr
4. DATE OF DEATH: Month: March Day: 8 Year: 19 62
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: June 18 1886
9. AGE (In years last birthday): 75 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: John William Whitmere
14. MOTHER'S MAIDEN NAME: Lydia Anne Olinger
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): -- (If yes give wars or dates of service): --
16. SOCIAL SECURITY NO.: None
17. INFORMANT: John W. Schorr Address: 7305-Willow Ave T.P.Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSE BY: IMMEDIATE CAUSE (a) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: Immediate
DUE TO (b) Hypertensive Cardiovascular Disease — 6-8 yrs.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (~~this hospital~~) attended the deceased from ... 1959 to 3/8 ..., 1962, that (I) (~~we~~) last saw the deceased alive on 3/8 1962, and that death occured at 10 P.M. from the causes and on the date stated above

22a. SIGNATURE: Charles E. Woodson M.D.
ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED: 3/8/62
22c. PHYSICIAN'S NAME (Type): CHARLES E. WOODSON
22d. ADDRESS: 1801 Eye St. N.W. Wash. 6, D.C.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 3/12/62
23c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Cemetery
23d. LOCATION (City, town or county) (State): Prince Georges County, Md.

24. FUNERAL DIRECTOR'S SIGNATURE: The S.H.Hines Co.
ADDRESS: 2901 14th St., N.W. Washington 9, D.C.
25a. REC'D BY REGISTRAR DATE: MAR 12 '62
25b. REGISTRAR'S SIGNATURE: Arthur S. Piraino

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03523 **CERTIFICATE OF DEATH** 03516

Item 23b, Film G,C,7 2/16/62 1wk

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda (Rural)
c. LENGTH OF STAY IN 1b: 40 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): U. S. Naval Hospital

2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)
a. STATE: North Carolina
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Lowell
d. STREET ADDRESS: Box 95
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

70 X 2

3. NAME OF DECEASED (Type or print): First: Donna; Middle: Lynn; Last: Scott

4. DATE OF DEATH: Month: March; Day: 12; Year: 1962

5. SEX: Female

6. COLOR OR RACE: Caucasian

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: January 21, 1962

9. AGE (In years last birthday): - yrs. IF UNDER 1 YEAR: Months 1, Days 20 IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Child

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): North Carolina

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Gus E. Scott

14. MOTHER'S MAIDEN NAME: Edna Ann Falls

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No (If yes give war or dates of service):

16. SOCIAL SECURITY NO.: - - - - -

17. INFORMANT: Hospital Records — Address:

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARTHROGRYPOSIS MULTIPLEX CONGENITA

758.6

DUE TO (b)

DUE TO (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

MEDICAL CERTIFICATION

21 I **certify** that ☒ (this hospital) attended the deceased from Feb. 1, ....., 1962, to March 12, 19.62 that ☒ (we) last saw the deceased alive on March 12, .....19....62 and that death occured at 10 A.M. P.M. from the causes and on the date stated above.

22a. SIGNATURE: Bernard H. Feldman M.D.

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: March 13, 1962

22c. PHYSICIAN'S NAME (Type): BERNARD H. FELDMAN LT MC USN

22d ADDRESS: U.S. Naval Hospital, Bethesda, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b DATE THEREOF: March 15, 1962

23c NAME OF CEMETERY OR CREMATORY: Gaston Memorial

23d. LOCATION (City, town or county) (State): Gastonia, North Carolina

24 FUNERAL DIRECTOR'S SIGNATURE: Charles W. Johnson ADDRESS: Rinaldi Funeral Home, 7400 Georgia Ave., WDC

25a. REC'D BY REGISTRAR DATE MAR 14 '62

25b. REGISTRAR'S SIGNATURE: C. Ivan S. Niven

**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 2 should be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

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# MARYLAND STATE DEPARTMENT OF HEALTH

**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

03524 **CERTIFICATE OF DEATH** 03517

1. PLACE OF DEATH
a. COUNTY: Montgomery
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Kensington
c. LENGTH OF STAY IN 1b: 5 yrs.
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Carroll Hall Sanitarium

2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Westhaven
d. STREET ADDRESS: 5110 Brookview Drive
a. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Charles Middle: Edward Last: Sebastian, Sr.
4. DATE OF DEATH: Month: March Day: 3 Year: 19 62
5. SEX: male
6. COLOR OR RACE: white
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 9/12/1880
9. AGE (in years last birthday): 81 yrs. IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ret. Bureau Engraving U. S. Gov't
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Washington, D. C.
12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME: Edward Sebastian
14. MOTHER'S MAIDEN NAME: Roberta Dyer
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: none
17. INFORMANT: Charles E. Sebastian, Jr. Address 5110 Brookview Dr. Westhaven, Md.

**MEDICAL CERTIFICATION**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Myocardial Infarction
DUE TO (b) Coronary Arteriosclerosis
DUE TO (c) Generalized Arteriosclerosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
INTERVAL BETWEEN ONSET AND DEATH: 1 hr.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 1/10/ 1959 to 3/3/ 1962 that (I) (we) last saw the deceased alive on 3/2/ 1962 and that death occured at 9:20 A.M. from the causes and on the date stated above.

22a. SIGNATURE: E. Stuart Lyddane M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type): E. Stuart Lyddane, M.D.
22d. ADDRESS: 9066 Georgia Ave.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 3/6/62
23c. NAME OF CEMETERY OR CREMATORY: Oak Hill Cemetery
23d. LOCATION (City, town or county) (State): Washington, D. C.

24 FUNERAL DIRECTOR'S SIGNATURE: The S. H. Hines Co.
ADDRESS: Washington, D. C.
25a. REC'D BY REGISTRAR DATE MAR 5 '62
25b. REGISTRAR'S SIGNATURE: Louis L. Hines

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

03525

## CERTIFICATE OF DEATH

03518

**1. PLACE OF DEATH**
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda (rural)
c. LENGTH OF STAY IN 1b: 104 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): U.S. Naval Hospital

**2. USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
a. STATE: North Carolina
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Concord
d. STREET ADDRESS: 254 N. Church St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

**3. NAME OF DECEASED** (Type or print): First: Marvin — Middle: Walter — Last: SECHLER

**4. DATE OF DEATH**: Month: March — Day: 1 — Year: 1962

**5. SEX**: Male

**6. COLOR OR RACE**: Cauc

**7. MARRIED** ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

**8. DATE OF BIRTH**: 8 November 1939

**9. AGE** (In years last birthday): 22 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): USN

**10b. KIND OF BUSINESS OR INDUSTRY**:

**11. BIRTHPLACE** (County & State, or foreign country): North Carolina

**12. CITIZEN OF WHAT COUNTRY?**: USA

**13. FATHER'S NAME**: Marshall Sechler

**14. MOTHER'S MAIDEN NAME**: Hedgie Wray

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unknown): Yes — (If yes give war or dates of service):

**16. SOCIAL SECURITY NO.**:

**17. INFORMANT**: Mother: Hedgie Sechler — Address:

**MEDICAL CERTIFICATION**

**18. CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Rhabdomyosarcoma, retroperitoneal — INTERVAL BETWEEN ONSET AND DEATH: 18 mo.

197.9

DUE TO (b)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

**19. WAS AUTOPSY PERFORMED?** YES ☐ NO ☐

**20a. ACCIDENT WAS UNDERLYING** ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

**20b. DESCRIBE HOW INJURY OCCURRED.** (Enter nature of injury in Part I or Part II of item 18.)

**20c. TIME OF INJURY** Hour a.m. p.m. — Month, Day, Year 19

**20d. INJURY OCCURRED** While at work ☐ Not While at work ☐

**20e. PLACE OF INJURY** (Home, farm, factory, street, office bldg., etc.)

**20f.** (City or town) (County) (State)

**21. I certify** that (X) (this hospital) attended the deceased from 17 November 1961 to 1 March, 1962, that (X) (we) last saw the deceased alive on 1 March 19 62, and that death occured at 4:15 PM from the causes and on the date stated above.

**22a. SIGNATURE**: A. T. Thorp

**22b. DATE SIGNED**: 2 March 1962

**22c. PHYSICIAN'S NAME** (Type): A.T. THORP, LCDR MC USN — MD — ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS ☒

**22d. ADDRESS**: U.S. NAVAL HOSPITAL, BETHESDA, MD.

**23a. BURIAL, CREMATION, REMOVAL** (Specify): Burial

**23b. DATE THEREOF**: 3/6/62

**23c. NAME OF CEMETERY OR CREMATORY**: Carolina Memorial

**23d. LOCATION** (City, town or county) (State): Concord, North Carolina

**24 FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS**: Tyson Wheeler Rockville Pike, Rockville, Md. Tyson Wheeler Funeral Home 1331 E. Montgomery Ave.

**25a. REC'D BY REGISTRAR** DATE MAR 5 '62

**25b. REGISTRAR'S SIGNATURE**: Arthur L. Kraus

**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7,61

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03526 **CERTIFICATE OF DEATH** 03519

**1. PLACE OF DEATH**
a. COUNTY: Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rockville
c. LENGTH OF STAY IN MARYLAND: 10
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 107 Dawson Avenue

**2. USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rockville
d. STREET ADDRESS: 107 Dawson Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

**3. NAME OF DECEASED** (Type or print): First ROBERT Middle GRANT Last SHAW

**4. DATE OF DEATH** Month March Day 10, Year 1962

**5. SEX** Male

**6. COLOR OR RACE** White

**7. MARRIED** ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

**8. DATE OF BIRTH** 6/19/89

**9. AGE** (In years last birthday) 72 yrs | IF UNDER 1 YEAR: Months, Days | IF UNDER 24 HRS: Hours, Min.

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): Ret. Carpenter

**10b. KIND OF BUSINESS OR INDUSTRY**: Building

**11. BIRTHPLACE** (County & State, or foreign country): Scotland

**12. CITIZEN OF WHAT COUNTRY?** Scotland

**13. FATHER'S NAME**: Unknown

**14. MOTHER'S MAIDEN NAME**: Unknown

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unknown): No
(If yes give war or dates of service)

**16. SOCIAL SECURITY NO.** 579-48-4629

**17. INFORMANT** Marion S. Shaw-Item # 2 Address

**18. CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

MEDICAL CERTIFICATION

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebrovascular accident — INTERVAL BETWEEN ONSET AND DEATH: 2 days
DUE TO (b) Arteriosclerosis, left hemiplegia. — 10 years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c): None

**19. WAS AUTOPSY PERFORMED?** YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

**21. I certify** that (I) (~~this hospital~~) attended the deceased from 1950, 19__, to March 10, 1962, that (I) (we) last saw the deceased alive on March 10 1962 and that death occured at 8:15 P.M. from the causes and on the date stated above.

22a. SIGNATURE: W. A. Lintheum, MD — M.D.
ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 3/10/62
22c. PHYSICIAN'S NAME (Type): Wm A. Lintheum
22d. ADDRESS: 110 S Washington St., Rockville, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Cremation
23b. DATE THEREOF: 3/13/62
23c. NAME OF CEMETERY OR CREMATORY: Ft. Lincoln
23d. LOCATION (City, town or county) (State): Prince George Co., Maryland

24. FUNERAL DIRECTOR'S SIGNATURE: Tyson Wheeler Funeral Home
ADDRESS: 1331 E. Montg. Ave. Rockville, Maryland

25a. REC'D BY REGISTRAR DATE MAR 13 '62
25b. REGISTRAR'S SIGNATURE: Clifton L. Kime

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death (page 3 should be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1 3

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

03527 **CERTIFICATE OF DEATH** 03520

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1

**1 PLACE OF DEATH** a. COUNTY: Montgomery — MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring

c. LENGTH OF STAY IN 1b: 9 years

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 2600 Terrapin Rd.

**2 USUAL RESIDENCE** (Where deceased lived. If institution Residence before admission) a. STATE: Maryland b. COUNTY: Montgomery

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring

d. STREET ADDRESS: 2600 Terrapin Rd.

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

**3 NAME OF DECEASED** (Type or print): First EVA Middle LEONA Last SHERMAN

**4. DATE OF DEATH** Month March Day 24 Year 1962

5. SEX: Female 6 COLOR OR RACE: White 7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Jan. 20, 1886 9. AGE (In years last birthday): 76 yrs IF UNDER 1 YEAR Month ~~2~~ Days ~~4~~ IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 10b KIND OF BUSINESS OR INDUSTRY: Home 11. BIRTHPLACE (State or foreign country): Wisconsin 12 CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Frank Ryder 14. MOTHER'S MAIDEN NAME: Juliet Sprague

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service) 16. SOCIAL SECURITY NO.: 477-16-4883D 17 INFORMANT: Mrs. Charles Preston, Address: 2600 Terrapin Rd. S.S. Md.

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).] INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Hemorrhagic Pancreatitis — 24 hrs

DUE TO (b) Severe Rheumatoid Arthritis

DUE TO (c) Treated with Cortisone — 3 years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause ost. 7220

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Generalized Osteoporosis

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21 **I certify** that (I) (this hospital) attended the deceased from Dec 1 1959 to March 24 1962 that (I) (we) last saw the deceased alive on March 24 1962 and that death occurred at 8 A.M. from the causes and on the date stated above

22a SIGNATURE: John J. Curry M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ 22b. DATE SIGNED 3/24/62

22c PHYSICIAN'S NAME (Type): JOHN J. CURRY 22d ADDRESS: 10620 Georgia Ave Silver Spring Md

23a BURIAL, CREMATION, REMOVAL (Specify): BURIAL 23b DATE THEREOF: 3/28/62 23c NAME OF CEMETERY OR CREMATORY: CRYSTAL LAKE CEMETERY 23d. LOCATION (City, town, or county): MINNEAPOLIS (State) MINNESOTA

24. FUNERAL DIRECTOR'S SIGNATURE: Stephen A. Zska ADDRESS: 8434 Georgia Ave. WARNER E. PUMPHREY INC SILVER SPRING, MARYLAND

25a REC'D BY REGISTRAR DATE MAR 27 62 25b. REGISTRAR'S SIGNATURE: Carlton L. Travis

**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 15M 9/59

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03528 **CERTIFICATE OF DEATH** 03521

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park,
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Washington Sanitarium and Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Marylnd
b. COUNTY: Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Greenbelt,
d. STREET ADDRESS: 2 Empire Place,
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First — Middle — Last: Shoemaker

4. DATE OF DEATH: Month March, Day 6, Year 19 62

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: March 6, 1962
9. AGE (In years last birthday) yrs.: IF UNDER 1 YEAR Months Days; IF UNDER 24 HRS. Hours Min. 10

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none
10b. KIND OF BUSINESS OR INDUSTRY: none
11. BIRTHPLACE (County & State, or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Thomas Edison Shoemaker
14. MOTHER'S MAIDEN NAME: Betty Joyce Matney

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): no
(If yes give war or dates of service): no
16. SOCIAL SECURITY NO.: no
17. INFORMANT: father — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): ASPHYXIATION — INTERVAL BETWEEN ONSET AND DEATH: 10 min
DUE TO (b): TIGHT LOOP CORD AROUND NECK — 10 min
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): None

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I **certify** that (I) (this hospital) attended the deceased from ..... 19 .., to ..... 19 ....., that (I) (we) last saw the deceased alive on ..... 19 ....., and that death occured at ..... M, from the causes and on the date stated above.

22a. SIGNATURE: [signature] M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 3/6/62
22c. PHYSICIAN'S NAME (Type): HAROLD STERLING
22d. ADDRESS: 1352 Kennedy Blvd E.

23a. BURIAL, CREMATION, REMOVAL (Specify): Cremation
23b. DATE THEREOF: 3-6-62
23c. NAME OF CEMETERY OR CREMATORY: Washington Sanitarium and Hospital, Takoma Park, Md.
(City, town or county) (State)

24 FUNERAL DIRECTOR'S SIGNATURE: Robert A. Hare, M. D.
ADDRESS: Washington San. & Hospital
25a. REC'D BY REGISTRAR DATE MAR 8 '62
25b. REGISTRAR'S SIGNATURE: Arthur L. Hance

**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03529 **CERTIFICATE OF DEATH** 03522

1. PLACE OF DEATH
a. COUNTY: Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 15 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): The Clinical Center, Bethesda 14, Md.

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Virginia
b. COUNTY: Fairfax
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Falls Church
d. STREET ADDRESS: 1224 West Greenstead Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Bessie; Middle: Mae; Last: Shupe

4. DATE OF DEATH: Month: March; Day: 17; Year: 19 62

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: October 22, 1926
9. AGE (In years last birthday): 35 yrs. IF UNDER 1 YEAR: Months / Days; IF UNDER 24 HRS.: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (County & State, or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Lester Craig
14. MOTHER'S MAIDEN NAME: Pearl Craig

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: 228-28-4986
17. INFORMANT: The Medical Record
Address: The Clinical Center, Bethesda 14, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac arrest — INTERVAL BETWEEN ONSET AND DEATH
DUE TO
(b) Auricular flutter — 1 1/2 hrs.
DUE TO
(c) Renal failure — 13 years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Primary hyperparathyroidism

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I **certify** that ☒ (this hospital) attended the deceased from March 2, 1962 to March 17, 1962, that ☐ (we) last saw the deceased alive on March 17, 1962, and that death occured at 10:40PM, from the causes and on the date stated above.

22a. SIGNATURE: Albert Ayerst Carr M.D.
22b. DATE SIGNED: 3/18/62
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22c. PHYSICIAN'S NAME (Type): Albert Ayerst Carr, M.D.
22d. ADDRESS: The Clinical Center, National Institutes of Health, Bethesda 14, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 3/20/62
23c. NAME OF CEMETERY OR CREMATORY: Spoon Creek Cemetery
23d. LOCATION (City, town or county) (State): Critz, Patrick Co. Va.

24. FUNERAL DIRECTOR'S SIGNATURE: Robert A. Humphrey
ADDRESS: Bethesda, Maryland
25a. REC'D BY REGISTRAR DATE MAR 20 '62
25b. REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

YR A15 (4)
15M 9/60

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FOR STATE HEALTH DEPT.

M

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03530 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 03523

**1. PLACE OF DEATH**
a. COUNTY: Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
c. LENGTH OF STAY IN 1b: MARYLAND
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Wash. San. + Hosp.

**2. USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
d. STREET ADDRESS: 75 E. Wayne Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Fanny; Middle: (nmn); Last: Siegel

4. DATE OF DEATH: Month: 3; Day: 2; Year: 1962

5. SEX: Female
6. COLOR OR RACE: Wh.
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: April 0 – 1891
9. AGE (In years last birthday): 70 yrs. IF UNDER 1 YEAR: Months / Days; IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): Russia
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME: Samuel Friedman
14. MOTHER'S MAIDEN NAME: Annie Glass
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service): —
16. SOC. AL SECURITY NO.: NONE
17. INFORMANT: Daughter — Mrs. Sally Goldstein Address (same as 2d above)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
(a) IMMEDIATE CAUSE: Coronary occlusion
DUE TO
(b)
DUE TO
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: Sudden

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Frank J. Broschart M.D.
EXAMINER'S NAME (Type): FRANK J. BROSCHART
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county):
DATE SIGNED: Mar 2 1962

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 3/4/1962
22c. NAME OF CEMETERY OR CREMATORY: NAT'L. MEM PARK
22d. LOCATION (City, town, or country): FALLS CHURCH. VA. (State)
23. FUNERAL DIRECTOR: Hadley Funeral Home
ADDRESS: 4217-9th Street
24a. REC'D BY REGISTRAR: DATE MAR 5 '62
24b. REGISTRAR'S SIGNATURE: Lawrence S. Krause

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, if possible, and as necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3 Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AISME
5M 9 6D

# MARYLAND STATE DEPARTMENT OF HEALTH

**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

03531 **CERTIFICATE OF DEATH** 03524

1. PLACE OF DEATH
a. COUNTY: Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: MARYLAND
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Suburban Hospital

2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
d. STREET ADDRESS: 6005 Landon Lane
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Hope; Middle: Dalberta; Last: Slone

4. DATE OF DEATH: Month: March; Day: 14; Year: 19 62

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Dec. 19, 1905

9. AGE (In years last birthday): 56 yrs. IF UNDER 1 YEAR: Months 2, Days 25; IF UNDER 24 HRS: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: ———

11. BIRTHPLACE (County & State or foreign country): Ohio

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: W. J. Hewitt

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)

16. SOCIAL SECURITY NO.: Unknown

17. INFORMANT: Horace E. Slone-Husband-same 2d Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

| | | Interval between onset and death |
|---|---|---|
| 1. IMMEDIATE CAUSE (a) | Uremia | 4 days |
| 2. DUE TO (b) | Dehydration + starvation from Pyloric obst. | 2 weeks |
| 3. DUE TO (c) | Carcinoma of Pancreas | 8 months |

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (~~this hospital~~) attended the deceased from 11 July, 1961, to 14 March, 1962, that (I) (we) last saw the deceased alive on 13 March 1962, and that death occurred at 12:55 A.M., from the causes and on the date stated above.

22a. SIGNATURE: John G. Ball M.D.

22b. DATE SIGNED: 3/14/62

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22c. PHYSICIAN'S NAME (Type): John G. Ball

22d. ADDRESS: Bethesda, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial-Transit

23b. DATE THEREOF: 3/17/62

23c. NAME OF CEMETERY OR CREMATORY: Sandyville Cemetery

23d. LOCATION (City, town or county) (State): Sandyville, Ohio

24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Robert A. Pumphrey, Bethesda, Maryland

25a. REC'D BY REGISTRAR DATE: MAR 16 '62

25b. REGISTRAR'S SIGNATURE: [illegible]

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Please retain the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

FOR STATE HEALTH DEPT.

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03532 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 03525

1. PLACE OF DEATH
a. COUNTY: Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN ib: 2½ days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Suburban

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
d. STREET ADDRESS: 14 Beltsville Rd. Box 76 Colesville/
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Everett Middle L. Last Smith
4. DATE OF DEATH: Month March Day 14, Year 1962
5. SEX: Male
6. COLOR OR RACE: Col.
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 9/2/28
9. AGE (In years last birthday): 33.34 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farm Work
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Walter Smith
14. MOTHER'S MAIDEN NAME: Evelyn Warner
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): no
16. SOCIAL SECURITY NO. (If yes give were or dates of service):
17. INFORMANT: Walter Smith, father — Address: same as above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral & pulmonary edema
DUE TO (b) Smoke inhalation
DUE TO (c) 3rd degree burns - Chest + upper extremes.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: 3 days

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Acute pancreatitis

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) Bed + clothing caught afire while smoking
20c. TIME OF INJURY Hour 7:45 a.m. p.m. Month, Day, Year 3-11 1962
20d. INJURY OCCURRED While at work ☐ Not While at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home
20. (City or town) Silver Spring (County) Mont. (State) Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐ and in my opinion death resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Frank J. Broschart M.D.
EXAMINER'S NAME (Type): FRANK J. Broschart
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☐
Address (Street, city, town, or county):
DATE SIGNED: 3-15-62

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 3/17/62
22c. NAME OF CEMETERY OR CREMATORY: Good Hope.,
22d. LOCATION (City, town, or country): Colesville, Md. (State)

23. FUNERAL DIRECTOR: Robert L. Snowden ADDRESS: Rockville, Md.
24a. REC'D BY REGISTRAR DATE MAR 19 '62
24b. REGISTRAR'S SIGNATURE: Catherine L. Hines

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If an autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. ASME 5M 9,60

# MARYLAND STATE DEPARTMENT OF HEALTH

**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

03533 **CERTIFICATE OF DEATH** 03526

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1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 3 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Suburban

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Md.
b. COUNTY: Mont. Co.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chevy Chase
d. STREET ADDRESS: 4136 - Leland St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

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3. NAME OF DECEASED (Type or print): First: Irene — Middle: B. — Last: Smith
4. DATE OF DEATH: Month: 3 — Day: 19 — Year: 1962

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 1/26/85
9. AGE (In years last birthday): 77 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Practical Nurse private
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Washington D.C.
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: William T. Burdine
14. MOTHER'S MAIDEN NAME: Susie France Wagner

I

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service):
16. SOCIAL SECURITY NO.: 301-10-9845
17. INFORMANT: Adelia T. Toomey — Address: 55 Above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Perforation Small Bowel
DUE TO (b) Strangulated Hernia in Obturator Foramen
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: 46 hours / 5 days

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (~~this hospital~~) attended the deceased from 3-14, 1962 to 3-19, 1962, that (I) (~~we~~) last saw the deceased alive on 3-19 1962 and that death occured at 2:20 PM from the causes and on the date stated above.

22a. SIGNATURE: P. P. Andrews
22b. DATE SIGNED: 3-19-62
22c. PHYSICIAN'S NAME (Type): P. P. Andrews, M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22d. ADDRESS: 4201 Fessenden St. N. W., Wash DC

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 3/22/62
23c. NAME OF CEMETERY OR CREMATORY: Arlington Cemetery
23d. LOCATION (City, town or county) (State): Arlington, Virginia

24. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: Robert A. Pumphrey, Bethesda, Maryland
25a. REC'D BY REGISTRAR DATE: MAR 22 62
25b. REGISTRAR'S SIGNATURE: Arthur L. Turner

**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03534 **CERTIFICATE OF DEATH** 03527

**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural
c. LENGTH OF STAY IN 1b: 2 yrs 5 mos
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Waverley Sanitarium

2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)
a. STATE: D.C.
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington DC. 47X3
d. STREET ADDRESS: 2301 Conn AVE NW.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Mildred Middle: Duvall Last: Smoot

4. DATE OF DEATH: Month: March Day: 16 Year: 1962

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 3/6/1896
9. AGE (In years last birthday): 66 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Montg. Cty, School Teacher
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Washington, D.C.
12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: Nelson H askell Duvall
14. MOTHER'S MAIDEN NAME: Georganne Williams

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
(If yes give war or dates of service):
16. SOCIAL SECURITY NO.: 219-36-7655 UNKNOWN
17. INFORMANT: Richard Kudlich, Kensington, Md. Address: Nephew

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a) (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Vascular Accident
DUE TO (b): Hypertension.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH: [redacted] Yrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Oct 16, 1959 to March 16, 1962 that (I) (~~saw~~) last saw the deceased alive on March 15, 1962, and that death occured at 12:05 P.M. from the causes and on the date stated above.

22a. SIGNATURE: C J Everding, M.D. M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 3/16/62
22c. PHYSICIAN'S NAME (Type): C. J. Everding
22d. ADDRESS: 4401 East-West Highway, Beth. Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Cremation
23b. DATE THEREOF: 3/16/62
23c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Crematory
23d. LOCATION (City, town or county) (State): Suitland, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Robert A. Pumphrey, Bethesda, Maryland
25a. REC'D BY REGISTRAR DATE: MAR 19 '62
25b. REGISTRAR'S SIGNATURE: Clifford L. Stone

VR A15 (4)
15M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

03535 03528

**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Olney
c. LENGTH OF STAY IN 1b: 4 yrs
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Brooke Grove Foundation

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Md
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 46 Silver Spring
d. STREET ADDRESS: 2215 Kimball Place
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Laird — Middle: Wingate — Last: Snell

4. DATE OF DEATH: Month: March — Day: 24 — Year: 1962

5. SEX: Male
6. COLOR OR RACE: Cauc
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Oct 30 1870
9. AGE (In years last birthday): 91 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clergyman
10b. KIND OF BUSINESS OR INDUSTRY: Religion
11. BIRTHPLACE (County & State, or foreign country): Minne
12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME: William Snell
14. MOTHER'S MAIDEN NAME: Elizabeth Faye

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
(If yes give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT: W. Wingate Snell — Address: 2215 Kimball ave Sil Sp Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
4. IMMEDIATE CAUSE (a): Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 5 days
DUE TO (b): Arteriosclerotic Heart Disease — YRS
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Nov. 1959 to March 24 1962, that (I) (we) last saw the deceased alive on 3-20 1962, and that death occured at 6:00 A.M. from the causes and on the date stated above.

22a. SIGNATURE: C. Wilson M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 3/24/62
22c. PHYSICIAN'S NAME (Type): C. H. Wilson
22d. ADDRESS: Sandy Spring, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): TRANSIT-BURIAL 3/25/62
23b. DATE THEREOF
23c. NAME OF CEMETERY OR CREMATORY: FAIRHOPE CEMETERY
23d. LOCATION (City, town, or county): FAIRHOPE, BALDWIN CO., ALABAMA (State)

24. FUNERAL DIRECTOR'S SIGNATURE: Raymond A. Zissa
WARNER E. PUMPHREY, INC., SILVER SPRING, MD.

25a. REC'D BY REGISTRAR — DATE: MAR 30 '62
25b. REGISTRAR'S SIGNATURE: Clifton E. Frame

FOR STATE HEALTH DEPT.

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03536

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03529

Item 11 Film 6308 3/9/62 Eh

**1. PLACE OF DEATH**
a. COUNTY: Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
c. LENGTH OF STAY IN 1b: 7 mo
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Belmont Nursing Home

**2. USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
a. STATE: Md
b. COUNTY: Mont
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Wheaton
d. STREET ADDRESS: 11514 Georgia Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Abraham; Middle: Solomon; Last:
4. DATE OF DEATH: Month: Mar; Day: 1; Year: 1962
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 12-14-73
9. AGE (In years last birthday): 88 yrs. IF UNDER 1 YEAR: Months / Days; IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Butcher (Retired)
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): DC
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Eli Solomon
14. MOTHER'S MAIDEN NAME: Cecelia (Unknown)
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 578-12-0598
17. INFORMANT: Nursing Home Record; Address:

**MEDICAL CERTIFICATION**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary occlusion
DUE TO (b): Arteriosclerosis
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: sudden / months

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from. Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Frank J. Broschart M.D.
EXAMINER'S NAME (Type): FRANK J. BROSCHART
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county):
DATE SIGNED: 3-1-62

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 3-5-62
22c. NAME OF CEMETERY OR CREMATORY: Wash. Hebrew Congregation
22d. LOCATION (City, town, or country): Wash. (State): D.C.

23. FUNERAL DIRECTOR: Francis J. Collins
ADDRESS: 3821-14th St. N.W. Wash. D.C.
24a. REC'D BY REGISTRAR DATE: MAR 5 '62
24b. REGISTRAR'S SIGNATURE: [illegible]

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any [illegible] is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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5M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

03537 03530

**ATTENDING PHYSICIAN:** The law requires that the death certificate be executed in 24 hours after death. Page 1 should be retained by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**1. PLACE OF DEATH**
a. COUNTY: Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: 10 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Washington Sanitarium & Hospital

**2. USUAL RESIDENCE** (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
d. STREET ADDRESS: 8100 Hammond Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

**3. NAME OF DECEASED** (Type or print): First HARRY Middle J. Last SCUDER

**4. DATE OF DEATH**: Month March Day 27 Year 1962

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 1-8-92
9. AGE (in years last birthday): 70 yrs — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): U.S. Govt. - Retired Photo Engraver-Army Map Service
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): D.C.
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Joseph A. Souder
14. MOTHER'S MAIDEN NAME: Dora Charlotte Reckeweg
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): yes (If yes give war or dates of service): WWI
16. SOCIAL SECURITY NO.: no
17. INFORMANT: Wash San - Hosp Chart

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Congestive Heart Failure
DUE TO (b): Acute myocardial Infarction
DUE TO (c): Coronary Artery Disease

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: 1 yr ?

PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Diabetes?

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 3/18 19.62 to 3/27 19.62 that (I) (we) last saw the deceased alive on 3/26 19.62 and that death occured at 7:12 A.M. from the causes and on the date stated above.

22a. SIGNATURE: C A Hobbs, M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type): Chas H Wolohan M
22d. ADDRESS: 7401 Blair Road, N.W. Wash. D.C.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 3/30/1962
23c. NAME OF CEMETERY OR CREMATORY: Arlington National Cem. - Arlington, Virginia
23d. LOCATION (City, town or county) (State)

24. FUNERAL DIRECTOR'S SIGNATURE: H. Hines Co.
ADDRESS: 2901 14th St NW
25a. REC'D BY REGISTRAR DATE MAR 29 '62
25b. REGISTRAR'S SIGNATURE: Arthur S. Kirma

VR A1S (4)
15M 7 61

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03538 **CERTIFICATE OF DEATH** 03531

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: 22 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Washington Sanitarium & Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Takoma Park, Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
d. STREET ADDRESS: 717 Erie Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Junius — Middle: Early — Last: Sowers

4. DATE OF DEATH: Month: March — Day: 14 — Year: 1962

5. SEX: Male

6. COLOR OR RACE: Caucasian

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 7-14-86

9. AGE (In years last birthday): 75 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Engineer - Boiler Room

10b. KIND OF BUSINESS OR INDUSTRY: Engineer - College

11. BIRTHPLACE (County & State, or foreign country):

12. CITIZEN OF WHAT COUNTRY? American

13. FATHER'S NAME: John W Sowers

14. MOTHER'S MAIDEN NAME: Demerris Dickerson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Unknown — (If yes give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Chief — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSE BY: IMMEDIATE CAUSE (a) Subphrenic abscess

DUE TO (b) Leak thru stomach wall

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) Partial resection of stomach for ulcer

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Congestive heart disease

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21 I certify that (I) (this hospital) attended the deceased from Feb 20, 1962 to Mar. 14, 1962, that (I) (we) last saw the deceased alive on March 14, 1962, and that death occured 6:50 p.M. from the causes and on the date stated above.

22a. SIGNATURE: W W Eastman M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): W. W. EASTMAN

22d. ADDRESS: 8700 Colesville Rd, Silver Spring Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: March 16, 1962

23c. NAME OF CEMETERY OR CREMATORY: George Washington Cemetery

23d. LOCATION (City, town or county) (State): Adelphi. Maryland.

24 FUNERAL DIRECTOR'S SIGNATURE: J. Arthur Walters — ADDRESS: 254 Carroll St. N.W. Wash. D.C.

25a. REC'D BY REGISTRAR DATE: MAR 19 62

25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

# MARYLAND STATE DEPARTMENT OF HEALTH

**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

03539 **CERTIFICATE OF DEATH** 03532

**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed 24 hours after death. Page 4 must be retained by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
1SM 9/60

1. PLACE OF DEATH
a. COUNTY: Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 9 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Suburban Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
d. STREET ADDRESS: 2300 Colston Drive—Apt. 102
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Madge; Middle: S. (Shaw); Last: Sponseller
4. DATE OF DEATH: Month: March; Day: 3; Year: 1962
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 9/18/78
9. AGE (In years last birthday): 83 yrs. IF UNDER 1 YEAR: Months / Days; IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (County & State, or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Frank T. Shaw
14. MOTHER'S MAIDEN NAME: Myra Cull
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No.
(If yes give war or dates of service): None
16. SOCIAL SECURITY NO: None
17. INFORMANT: Donald Sponseller Address: 36 Count St. ~~Westminster,~~ Westminster, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

| | | Interval between onset and death |
|---|---|---|
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) | Cerebral Hemorrhage | 8 days |
| DUE TO (b) | Arteriosclerotic Heart Disease | ? |
| DUE TO (c) | | |

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from ..... 1937, to 3/3 ....., 1962, that (I) (we) last saw the deceased alive on March 2 ... 1962 and that death occured at 5:30 A.M. from the causes and on the date stated above.

22a. SIGNATURE: J. Marion Bankhead M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 3/3/62
22c. PHYSICIAN'S NAME (Type): J. Marion Bankhead
22d. ADDRESS: 9241 Col. Blvd. Silver Spring Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 3-5-62
23c. NAME OF CEMETERY OR CREMATORY: Westminster Cemetery
23d. LOCATION (City, town or county) (State): Westminster Carroll Co. Md.

24. FUNERAL DIRECTOR'S SIGNATURE: Raymond A. Zeiler ADDRESS: 8434 Georgia Ave
Warner E. Pumphrey, Inc. Silver Spring, Maryland
25a. REC'D BY REGISTRAR DATE: MAR 7 '62
25b. REGISTRAR'S SIGNATURE: Arthur S. Thomas

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03540 **CERTIFICATE OF DEATH** 03533

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 3 should be retained by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda (Rural)
c. LENGTH OF STAY IN Ib: 7 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): U. S. Naval Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)
a. STATE: Maryland
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): College Park
d. STREET ADDRESS: 4212B Knox Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First — Middle — Last: Alford Palmer Stark
4. DATE OF DEATH: Month — Day — Year: March 26, 1962
5. SEX: Male
6. COLOR OR RACE: Caucasian
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: September 2, 1884
9. AGE (In years last birthday): 77 yrs — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Naval Officer
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Texas
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Jeremiah M. Stark
14. MOTHER'S MAIDEN NAME: Serena V. Mattox
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): Yes — (If yes give war or dates of service): WW I & WW II
16. SOCIAL SECURITY NO.:
17. INFORMANT: Wife: Mrs. Mae E. Stark, Same as #2 — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Adenocarcinoma of pancreas with widespread metatisis
DUE TO (b) Terminal intestinal hemorrhage
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21 I certify that I (this hospital) attended the deceased from March 19, 1962, to March 26, 1962, that I (we) last saw the deceased alive on March 26, 1962, and that death occured at 6:25 AM from the causes and on the date stated above.

22a. SIGNATURE: A. L. Kettering LT MC M.D
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: March 26, 1962
22c. PHYSICIAN'S NAME (Type): D. L. KETTERING LT MC USN
22d. ADDRESS: U. S. Naval Hospital, Bethesda, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 3-28-62
23c. NAME OF CEMETERY OR CREMATORY: Arlington National
23d. LOCATION (City, town or county) (State): Arlington, Virginia

24. FUNERAL DIRECTOR'S SIGNATURE: J. Stone — ADDRESS: GASCH FUNERAL HOME, HYATTSVILLE, MARYLAND
25a. REC'D BY REGISTRAR: DATE MAR 28 '62
25b. REGISTRAR'S SIGNATURE: Arthur E. Hume

VR A15 (4)
1SM 7/61

Item 18 Film 309 3-23

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03541 **CERTIFICATE OF DEATH** 03534

1. PLACE OF DEATH
a. COUNTY: Montgomery
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 23 Days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): The Clinical Center, Bethesda 14, Md.

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Louisiana
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bossier City
d. STREET ADDRESS: 433 Riverdale Drive
e. IS RESIDENCE ON A FARM? YES [ ] NO [X]

3. NAME OF DECEASED (Type or print): First: Chirley Middle: Ann Last: Stevens

4. DATE OF DEATH: Month: March Day: 16 Year: 1962

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: 14 January 1957
9. AGE (In years last birthday): 5 yrs. IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hours: Min.:
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Child
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (County & State, or foreign country): Louisiana
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Joel B. Stevens
14. MOTHER'S MAIDEN NAME: Roberta Summers
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service):
16. SOCIAL SECURITY NO.: None
17. INFORMANT: The Medical Record, Address: The Clinical Center, Bethesda 14, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I. DEATH WAS CAUSED BY: (IMMEDIATE CAUSE (a)) Pneumonitis Cardiorepiratory Arrest — INTERVAL BETWEEN ONSET AND DEATH

204.5

DUE TO (b) Probable Septicemia — 3 Weeks

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c) Acute Lymphocytic Leukemia with Hepato splenomegaly — 1 Year

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES [X] NO [ ]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work [ ] Not While at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Feb. 21, 1962, to March 16, 1962 that (I) (we) last saw the deceased alive on March 16, 1962, and that death occured at 3:07 PM from the causes and on the date stated above.

22a. SIGNATURE: J. David Heywood M.D.
ATTENDING PHYS. [ ] MED. DIRECTOR [ ] STAFF PHYS. [X]
22b. DATE SIGNED: 3-16-62
22c. PHYSICIAN'S NAME (Type): J. David Heywood M.D. M.D.
22d. ADDRESS: The Clinical Center, National Institutes of Health, Bethesda 14, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 3/20/62
23c. NAME OF CEMETERY OR CREMATORY: HILL CREST CEMETERY
23d. LOCATION (City, town or county) (State): BOSSIER PARRISH LOUISIANA

24 FUNERAL DIRECTOR'S SIGNATURE: W. W. Chambers
ADDRESS: 1400 Chapin St. N.W. Wash. D.C.
25a. REC'D BY REGISTRAR DATE: MAR 20 '62
25b. REGISTRAR'S SIGNATURE: Carrie S. Kuns

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03542 **CERTIFICATE OF DEATH** 03535

**1. PLACE OF DEATH**
a. COUNTY: Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: MARYLAND
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Washington San. and Hospital

**2. USUAL RESIDENCE** (Where deceased lived, If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): W. Hyattsville
d. STREET ADDRESS: 6702 West Park Dr.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Carrie Middle: (NMN) Last: Stiefel
4. DATE OF DEATH: Month: March Day: 13 Year: 1962
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 10-5-89
9. AGE (In years last birthday): 72 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife
10b. KIND OF BUSINESS OR INDUSTRY: At Home
11. BIRTHPLACE (County & State, or foreign country): Hungary
12. CITIZEN OF WHAT COUNTRY? American
13. FATHER'S NAME: Adolph Fisher
14. MOTHER'S MAIDEN NAME: Julia Eckstein
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
16. SOCIAL SECURITY NO: 091-14-2349
17. INFORMANT: Park West Memorial Chapel — New York

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocardial infarction. — INTERVAL BETWEEN ONSET AND DEATH: 1 day
DUE TO (b) Hypertensive cardio-vascular disease — unknown
DUE TO (c)
420.1
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19 WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I **certify** that (I) ~~(this hospital)~~ attended the deceased from 2-23, 1962 to 3-13, 1962 that (I) ~~(we)~~ last saw the deceased alive on 3-13, 1962 and that death occured at (CS) P.M. from the causes and on the date stated above

22a. SIGNATURE: Eino Nagl, M.D.
22b. DATE SIGNED: 3-13-62
ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22c. PHYSICIAN'S NAME (Type): EINO NAGL
22d. ADDRESS: 915 Univ. Blvd. E. Silver Spring, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE THEREOF: 3/14/62
23c. NAME OF CEMETERY OR CREMATORY: Riverside Cemetery
23d. LOCATION (City, town or county) (State): Rochelle Park New Jersey

24 FUNERAL DIRECTOR'S SIGNATURE: Sol Levine & Bros Inc.
ADDRESS: 6010 Ristertown Rd.
25a. REC'D BY REGISTRAR DATE MAR 15 '62
25b REGISTRAR'S SIGNATURE: Charles E. Thomas

**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7 61

1

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03543 **CERTIFICATE OF DEATH** 03536

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1. PLACE OF DEATH
a. COUNTY: Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda (Rural)
c. LENGTH OF STAY IN 1b: 4 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): U. S. Naval Hospital

MARYLAND

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Wheaton
d. STREET ADDRESS: 3812 Greenly Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF [redacted] (Type or print): First: David; Middle: Hugh; Last: Strohmeyer

4. DATE OF DEATH: Month: March; Day: 15; Year: 1962

5. SEX: Male
6. COLOR OR RACE: Caucasian
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: December 22, 1961
9. AGE (In years last birthday): yrs.; IF UNDER 1 YEAR: Months 2, Days 21; IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): ------
10b. KIND OF BUSINESS OR INDUSTRY: ------
11. BIRTHPLACE (County & State, or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: John H. Strohmeyer
14. MOTHER'S MAIDEN NAME: Joyce Aileen Parr

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
(If yes give war or dates of service): ------
16. SOCIAL SECURITY NO.: ------
17. INFORMANT: Hospital Records
Address:

I

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Tricuspid Atresia (Post operative)
754.3 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)

INTERVAL BETWEEN ONSET AND DEATH: 2 1/2 mo.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I **certify** that (X) (this hospital) attended the deceased from March 12, 1962 to March 15, 1962, that (X) (we) last saw the deceased alive on March 15, 1962, and that death occured 4:21 PM from the causes and on the date stated above

22a. SIGNATURE: J. L. Beeby
22b. DATE SIGNED
M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22c. PHYSICIAN'S NAME (Type): J. L. BEEBY LT MC USN
22d. ADDRESS: U. S. Naval Hospital, Bethesda, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 3-19-62
23c. NAME OF CEMETERY OR CREMATORY: Arlington National
23d. LOCATION (City, town or county): Arlington, Virginia (State)

24. FUNERAL DIRECTOR'S SIGNATURE: Robert A. Pumphrey
ADDRESS: Bethesda, Md.
Robert A. Pumphrey Funeral Home, 7557 Wisc. Ave.
25a. REC'D BY REGISTRAR DATE: MAR 19 '62
25b. REGISTRAR'S SIGNATURE: Arthur S. Krause

**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 1 should be retained by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

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FOR STATE HEALTH DEPT.

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# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03544 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 03537

1. PLACE OF DEATH
a. COUNTY: Bethesda Montgomery MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 1 day
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Suburban Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
d. STREET ADDRESS: 4511 Amherst Lane
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Hazel, Middle V., Last Styers

4. DATE OF DEATH: Month March, Day 3, Year 19 62

5. SEX: Female

6. COLOR OR RACE: white

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Aug. 14, 1912

9. AGE (In years last birthday): 49 yrs. IF UNDER 1 YEAR: Months, Days; IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): ~~Va.~~ Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Henry Nine

14. MOTHER'S MAIDEN NAME: Claudie Baxley

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Paul - same as above - Husband Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral edema
DUE TO
(b) Cerebral hemorrhage
DUE TO
(c) Ruptured aneurysm - rt mid. cerebral artery

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: 19 hrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
Was pushing auto at home when she became ill + collapsed

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from. Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Frank J. Broschart M.D.

EXAMINER'S NAME (Type): FRANK J. Broschart

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county)

DATE SIGNED: Mar 3 1962

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 3/6/62

22c. NAME OF CEMETERY OR CREMATORY: Arlington Nat. Cem.

22d. LOCATION (City, town, or country): Arlington, Virginia (State)

23. FUNERAL DIRECTOR: Robert A. Pumphrey, Bethesda, Maryland ADDRESS

24a. REC'D BY REGISTRAR DATE MAR 7 '62

24b. REGISTRAR'S SIGNATURE: [illegible]

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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# MARYLAND STATE DEPARTMENT OF HEALTH

**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

03545 **CERTIFICATE OF DEATH** 03538

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): BETHESDA
c. LENGTH OF STAY IN 1b: MARYLAND 17 hrs.
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): SUBURBAN

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: D.C.
b. COUNTY:
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): WASHINGTON 16
d. STREET ADDRESS: 5510 Ridgefield Rd.
a. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): WILLIAM S. SUMMERS (First, Middle, Last)

4. DATE OF DEATH: March 10 1962 (Month, Day, Year)

5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 8/30/84
9. AGE (In years last birthday): 77 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): VIRGINIA
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: WILLIAM SUMMERS
14. MOTHER'S MAIDEN NAME: SARAH Unknown
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): NO
16. SOCIAL SECURITY NO.: 577 03 8558
17. INFORMANT: daughter Address: Same as above Mrs Olive C Connor

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebrovascular accident — INTERVAL BETWEEN ONSET AND DEATH: 2 days
DUE TO (b): Hypertension — 2 years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Arteriosclerosis
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Jan 2, 1962 to March 10, 1962 that (I) (we) last saw the deceased alive on March 10 1962 and that death occured at 10 A.M. from the causes and on the date stated above.

22a. SIGNATURE: Dr Joseph Kenrick
22b. DATE SIGNED: 3/10/62
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ M.D.
22c. PHYSICIAN'S NAME (Type): Dr Joseph P. Kenrick
22d. ADDRESS: 6450 Wisconsin Ave, Bethesda, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 3-13-1962
23c. NAME OF CEMETERY OR CREMATORY: Cedar Hill
23d. LOCATION (City, town or county) (State): Suitland, Md

24. FUNERAL DIRECTOR'S SIGNATURE: K. A. Mitchell by
ADDRESS: 131-11th St. S.E. Wash. DC
25a. REC'D BY REGISTRAR: DATE MAR 12 '62
25b. REGISTRAR'S SIGNATURE: [illegible]

**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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FOR STATE HEALTH DEPT.

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# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03546

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03539

**1. PLACE OF DEATH** a. COUNTY: Montgomery — MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda

c. LENGTH OF STAY IN 1b: D.O.A.

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Suburban Hospital ~~Westmorland Ave & Cedar Lane~~

**2. USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission) a. STATE: Md b. COUNTY: Mont

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 37 Wheaton

d. STREET ADDRESS: 3110 Henderson Ave.

e. IS RESIDENCE ON A FARM? YES [ ] NO [X]

**3. NAME OF DECEASED** (Type or print): First: Joyce Middle: Ellen Last: Twomey

**4. DATE OF DEATH** Month: 3 Day: 19 Year: 1962

**5. SEX:** Female **6. COLOR OR RACE:** White **7. MARRIED** [X] **NEVER MARRIED** [ ] **WIDOWED** [ ] **DIVORCED** [ ]

**8. DATE OF BIRTH:** 5/30/29 **9. AGE** (In years last birthday): 32 yrs. IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS.: Hours / Min.

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): Cafeteria Asst. ~~Reg. Nurse~~

**10b. KIND OF BUSINESS OR INDUSTRY:** Radnor Elementary School

**11. BIRTHPLACE** (State or foreign country): DC

**12. CITIZEN OF WHAT COUNTRY?** U.S.A.

**13. FATHER'S NAME:** Raymond Hough

**14. MOTHER'S MAIDEN NAME:** Louise Legge

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unkown): No (If yes give war or dates of service): None

**16. SOCIAL SECURITY NO:** 229-26-9888

**17. INFORMANT:** Bernard Sweeney Address: Route 2

**18. CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Laceration of Cord

DUE TO (b): Fracture & dislocation C5

DUE TO (c): Auto accident

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: Sudden

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

**19. WAS AUTOPSY PERFORMED?** YES [X] NO [ ]

MEDICAL CERTIFICATION

**20a. EXTERNAL CAUSE WAS** PRIMARY [X] or CONTRIBUTING [ ] CAUSE OF DEATH.

**20b. DESCRIBE HOW INJURY OCCURED.** (Enter nature of injury in Part I or Part II of item 18.) Was driver of car in which a truck upset

**20c. TIME OF INJURY** Hour: 7:25 p.m. Month, Day, Year: 3-19 1962

**20d. INJURY OCCURRED** While at work [ ] Not While at work [X]

**20e. PLACE OF INJURY** (Home, farm, factory, street, office bldg., etc.): Highway **20f.** (City or town): Bethesda (County): Mont (State): Md

21. I certify that I took charge of the remains described above, held an Autopsy [X], Inspection [ ], Inquiry [ ], and in my opinion death resulted from: Natural causes [ ], Accident [X], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE: Frank J. Broschart M.D.

EXAMINER'S NAME (Type): FRANK J. BROSCHART

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]

DATE SIGNED: 3-20-62

Address (Street, city, town, or county)

**22a. BURIAL, CREMATION, REMOVAL** (Specify): Burial **22b. DATE THEREOF:** 3-23-62

**22c. NAME OF CEMETERY OR CREMATORY:** Arlington National Cemetery **22d. LOCATION** (City, town, or country): Arlington, Virginia (State):

**23. FUNERAL DIRECTOR:** Raymond A. Zicka ADDRESS: 8434 Georgia Ave

Warner E. Pumphrey, Inc. Silver Spring, Md.

**24a. REC'D BY REGISTRAR** DATE: MAR 22 '62

**24b. REGISTRAR'S SIGNATURE:** Arthur S. Hume

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If an autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. ATSME 5M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

03547 03540

**1. PLACE OF DEATH**
a. COUNTY: Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Kensington
c. LENGTH OF STAY IN 1b: 2 weeks
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Carroll Hall Sanitarium

**2. USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
d. STREET ADDRESS: 6009 Rossmore Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

**3. NAME OF DECEASED** (Type or print): First MARY Middle ESTELLE Last SWOPE

**4. DATE OF DEATH**: Month March Day 18, Year 1962

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Nov. 3, 1879
9. AGE (In years last birthday): 82 yrs. IF UNDER 1 YEAR: Months 4 Days 15 IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Alexandria, Virginia
12. CITIZEN OF WHAT COUNTRY? U. S.
13. FATHER'S NAME: Manley T. Rust
14. MOTHER'S MAIDEN NAME: Mary Estelle Nevett
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No (If yes give war or dates of service):
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Daughter Address: Mrs. Dorothy Zimowski

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CEREBRAL THROMBOSIS — INTERVAL BETWEEN ONSET AND DEATH: 1 WK
DUE TO
(b) GENERALIZED ARTERIOSCLEROSIS — 10 YRS
DUE TO
(c) ADVANCING YEARS (OLD AGE)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from JAN 15, 1962 to 3/18, 1962 that (I) (we) last saw the deceased alive on 3/16, 1962 and that death occured at 4:10 P.M. from the causes and on the date stated above.

22a. SIGNATURE: [signature] M.D.
22b. DATE SIGNED: 3/19/62
22c. PHYSICIAN'S NAME (Type): GEO H DONOVAN M.D.
ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22d. ADDRESS: 8218 Wisconsin Ave., Bethesda, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 3/21/62
23c. NAME OF CEMETERY OR CREMATORY: Arlington Cemetery
23d. LOCATION (City, town or county) (State): Arlington, Virginia

24. FUNERAL DIRECTOR'S SIGNATURE: Robert A. Pumphrey
ADDRESS: Bethesda, Maryland
25a. REC'D BY REGISTRAR DATE: MAR 22 '62
25b. REGISTRAR'S SIGNATURE: [signature]

**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed in 24 hours after death. Page 1 may be retained by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03548 **CERTIFICATE OF DEATH** 03541

1 M 74 I 2 1

**1. PLACE OF DEATH**
a. COUNTY: Montgomery
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 25 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Suburban

**2. USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Rockville
d. STREET ADDRESS: 11901 Rockville Pike Lot J
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

**3. NAME OF DECEASED** (Type or print): First: Charles; Middle: T.; Last: Tavenner

**4. DATE OF DEATH**: Month: March; Day: 26; Year: 1962

**5. SEX**: Male

**6. COLOR OR RACE**: White

**7. MARRIED** ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

**8. DATE OF BIRTH**: 9/19/19

**9. AGE** (In years last birthday): 42 yrs.
IF UNDER 1 YEAR: Months | Days
IF UNDER 24 HRS.: Hours | Min.

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): Mover

**10b. KIND OF BUSINESS OR INDUSTRY**: Moving

**11. BIRTHPLACE** (County & State, or foreign country): Virginia

**12. CITIZEN OF WHAT COUNTRY?**: USA

**13. FATHER'S NAME**: Charles Welby Tavenner

**14. MOTHER'S MAIDEN NAME**: Mary Ellen MacDonough

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unkown) (If yes give war or dates of service): no

**16. SOCIAL SECURITY NO.**: 223-22-7786

**17. INFORMANT** Address:

**18. CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): PULMONARY EMBOLUS — INTERVAL BETWEEN ONSET AND DEATH: 1-2 h
DUE TO (b): THROMBOSIS, PERIPHERAL VEINS
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): DIABETES MELLITUS

**19. WAS AUTOPSY PERFORMED?** YES ☒ NO ☐

**20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

**20b. DESCRIBE HOW INJURY OCCURED.** (Enter nature of injury in Part I or Part II of item 18)

**20c. TIME OF INJURY** Hour a.m. p.m. Month, Day, Year 19

**20d. INJURY OCCURRED** While at work ☐ Not While at work ☐

**20e. PLACE OF INJURY** (Home, farm, factory, street, office bldg., etc.)

**20f.** (City or town) (County) (State)

**21. I certify** that (I) (~~this hospital~~) attended the deceased from March 19, 1962 to March 26, 1962 that (I) (~~we~~) last saw the deceased alive on March 26, 1962 and that death occured at 1:25 A.M. from the causes and on the date stated above.

**22a. SIGNATURE** M.D.: John E. Everett

**22b. DATE SIGNED**: 3/26/62

**22c. PHYS CIAN'S NAME** (Type): JOHN E EVERETT

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

**22d. ADDRESS**: 9400 Conn Av. Kensington Md

**23a. BURIAL, CREMATION, REMOVAL** (Specify): Burial

**23b. DATE THEREOF**: 3/29/62

**23c. NAME OF CEMETERY OR CREMATORY**: National Memorial Park

**23d. LOCATION** (City, town or county) (State): Falls Church Virginia

**24. FUNERAL DIRECTOR'S SIGNATURE**: Tyson Wheeler

ADDRESS: 1331 East Monty. Ave Rockville Maryland

**25a. REC'D BY REGISTRAR** DATE MAR 29 '62

**25b. REGISTRAR'S SIGNATURE**: Arthur S. Evans

MEDICAL CERTIFICATION

**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03549 **CERTIFICATE OF DEATH** 03542

1. PLACE OF DEATH
a. COUNTY: Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 183 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): The Clinical Center, Bethesda 14, Md.

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: District Of Columbia
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington
d. STREET ADDRESS: 1719 Monroe Street, N.E.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Mary Middle Louise Last Thomas
4. DATE OF DEATH: Month March Day 27, Year 1962
5. SEX: Female
6. COLOR OR RACE: Negro
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: September 13, 1896
9. AGE (In years last birthday): 65 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Seamstress
10b. KIND OF BUSINESS OR INDUSTRY: Clothing
11. BIRTHPLACE (County & State, or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: George W. Richards
14. MOTHER'S MAIDEN NAME: Lucinda Page
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): NO
16. SOCIAL SECURITY NO: 577-30-3756
17. INFORMANT: The Medical Records The Clinical Center, Bethesda 14, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY:

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | Progressive electrolyte imbalance | 6 months |
| DUE TO (b) | Macroglobulinemia with bone and renal disease | 8 months |
| DUE TO (c) | | |

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that ☒ (this hospital) attended the deceased from Sept. 25, 1961, to March 27, 1962 that (☒ (we) last saw the deceased alive on March 27, 1962, and that death occured at 8:25PM from the causes and on the date stated above.

22a. SIGNATURE: Michael Z. Lazor M.D.
22b. DATE SIGNED: 3/28/62
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22c. PHYSICIAN'S NAME (Type): Michael Z. Lazor, M.D.
22d. ADDRESS: The Clinical Center, National Institutes Of Health, Bethesda 14, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 3.30.62
23c. NAME OF CEMETERY OR CREMATORY: WOODLAWN CEMETERY
23d. LOCATION (City, town or county) (State): WASHINGTON, D.C.

24. FUNERAL DIRECTOR'S SIGNATURE: [signature]
ADDRESS: 1820 9TH ST, N.W. WASHINGTON, D.C.
25a. REC'D BY REGISTRAR DATE APR 2 '62
25b. REGISTRAR'S SIGNATURE: [signature]

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

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# MARYLAND STATE DEPARTMENT OF HEALTH

**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

03550 **CERTIFICATE OF DEATH** 03543

**1. PLACE OF DEATH**
a. COUNTY: Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 30 min.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Suburban Hospital

**2. USUAL RESIDENCE** (Where deceased lived, If Institution: Residence before admission)
a. STATE: D.C.
b. COUNTY: ✓
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington
d. STREET ADDRESS: 3133 Conn Ave. N.W.
a. IS RESIDENCE ON A FARM? YES ☐ NO ☒

47X-3

**3. NAME OF DECEASED** (Type or print): First: Virginia; Middle: A.; Last: Thompson

**4. DATE OF DEATH**: Month: March; Day: 13; Year: 1962

**5. SEX**: Female

**6. COLOR OR RACE**: White

**7. MARRIED** ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

**8. DATE OF BIRTH**: 12/29/79

**9. AGE** (In years last birthday): 82 yrs. | IF UNDER 1 YEAR: Months | Days | IF UNDER 24 HRS.: Hours | Min.

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): Retired

**10b. KIND OF BUSINESS OR INDUSTRY**: - - -

**11. BIRTHPLACE** (County & State, or foreign country): D.C.

**12. CITIZEN OF WHAT COUNTRY?**: U.S.A.

**13. FATHER'S NAME**: Maurice Adler

**14. MOTHER'S MAIDEN NAME**: Gertrude Harper

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unknown): No

**16. SOCIAL SECURITY NO.**: No

**17. INFORMANT**: Raymond Thompson, Son-in-law — Address: 119 Hesketh St. Ch. Ch., Md

**18. CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Congestive Heart Failure - Acute — INTERVAL BETWEEN ONSET AND DEATH: 12 hrs

DUE TO (b): Acute Myocardial Infarction — 1 mo

DUE TO (c): Arteriosclerosis

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

**19. WAS AUTOPSY PERFORMED?** YES ☐ NO ☐

MEDICAL CERTIFICATION

**20a.** ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

**20b.** DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

**20c.** TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19

**20d.** INJURY OCCURRED: While at work ☐ Not While at work ☐

**20e.** PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

**20f.** (City or town) (County) (State)

**21. I certify** that (I) (this hospital) attended the deceased from Feb 10, 1962 to March 13 1962 that (I) ~~(we)~~ last saw the deceased alive on 3/13, 1962, and that death occured at 10:00 AM, from the causes and on the date stated above.

**22a.** SIGNATURE: W. Fleet Luckett — M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

**22b.** DATE SIGNED

**22c.** PHYSICIAN'S NAME (Type): Dr. Wm. F. Luckett

**22d.** ADDRESS: 5000 Reno Road, N.W. Washington, D.C

**23a.** BURIAL, CREMATION, REMOVAL (Specify): Burial

**23b.** DATE THEREOF: 3-15-1962

**23c.** NAME OF CEMETERY OR CREMATORY: Oak Hill Cemetery

**23d.** LOCATION (City, town or county) (State): Washington, D. C.

**24** FUNERAL DIRECTOR'S SIGNATURE: Joseph Gawler & Sons, Inc. — ADDRESS: Washington 6, D.C. 1756 Pa. Ave. N.W.

**25a.** REC'D BY REGISTRAR — DATE: MAR 15 '62

**25b.** REGISTRAR'S SIGNATURE: Arthur E. Thomas

**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

03551 — Item 21 Film 6311 4/16/62 mh — 03544

**1. PLACE OF DEATH**
a. COUNTY: Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: 31 Days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Washington Sanitarium & Hospital

**2. USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 14 Ednor
d. STREET ADDRESS: 1 Millgrove Gardens
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Joseph; Middle: Franklin; Last: Tower

4. DATE OF DEATH: Month: March; Day: 31; Year: 1962

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 6-26-23
9. AGE (In years last birthday): 38 yrs. IF UNDER 1 YEAR: Months / Days. IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Construction Repr. National Park Service
10b. KIND OF BUSINESS OR INDUSTRY: National Park Serv
11. BIRTHPLACE (County & State, or foreign country): Michigan
12. CITIZEN OF WHAT COUNTRY? Amer.

13. FATHER'S NAME: Franklin Tower
14. MOTHER'S MAIDEN NAME: Florence Harder

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes give war or dates of service): WW-II
16. SOCIAL SECURITY NO.: 218-24-0844
17. INFORMANT: Hospital Records — Address:

**MEDICAL CERTIFICATION**

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardio-Respiratory Failure — INTERVAL BETWEEN ONSET AND DEATH: 24 hrs
DUE TO (b): Shock Post Operative — 72 hrs
DUE TO (c): Cordotomy

Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Adenocarcinoma Rectum with Gen. Metastasis

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from MAR 1, 1962 to MAR 31, 1962, that (I) (we) last saw the deceased alive on MAR 30, 1962, and that death occured at 4 AM, from the causes and on the date stated above.

22a. SIGNATURE: John P. Haberlin M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 3-31-62
22c. PHYSICIAN'S NAME (Type): John P. Haberlin
22d. ADDRESS: 1015 Spring Street, Silver Spring, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 4-3-62
23c. NAME OF CEMETERY OR CREMATORY: Arlington National Cemetery
23d. LOCATION (City, town or county) (State): Arlington, Virginia

24. FUNERAL DIRECTOR'S SIGNATURE: Raymond A. Zuber ADDRESS: 8434 Georgia Ave.
Warner E. Pumphrey, Inc. Silver Spring, Maryland
25a. REC'D BY REGISTRAR DATE APR 3 '62
25b. REGISTRAR'S SIGNATURE: Clifton L. Frank

**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03552 **CERTIFICATE OF DEATH** 03545

Item 9 Film 3209 3/19/62 iwk

**TO ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 3 should be retained by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7 61

1. PLACE OF DEATH
a. COUNTY: Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: 2 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Washington Sanitarium & Hospital

MARYLAND

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: D.C.
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington D.C. 47X
d. STREET ADDRESS: 808 Aspen Street, N.W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Carrie Middle: Ella Last: Trivett
4. DATE OF DEATH: Month 3 Day 12 Year 1962
5. SEX: F
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 3-26-1874
9. AGE (In years last birthday): 88 Years
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): New York
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Barnabas Vrooman
14. MOTHER'S MAIDEN NAME: Eleanor Smith
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
16. SOCIAL SECURITY NO.: no
17. INFORMANT: Mrs Engell (niece) Address: 808 Aspen St NW

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 36 hrs
DUE TO
(b) Hypertensive cardiovascular disease many yrs.
DUE TO
(c) Generalized arteriosclerosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
I 43X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (~~this hospital~~) attended the deceased from May, 1958 to 12 March, 1962 that (I) (~~we~~) last saw the deceased alive on 12 March 1962, and that death occured at 10:40 AM from the causes and on the date stated above.

22a. SIGNATURE: Ernest E. Harmon M.D.
22b. DATE SIGNED: 12 Mar 62
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22c. PHYSICIAN'S NAME (Type): Ernest E. Harmon M.D.
22d. ADDRESS: 9301 Colesville Rd Silver Spring Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 3-14-62
23c. NAME OF CEMETERY OR CREMATORY: Cedar Hill
23d. LOCATION (City, town or county) (State): Suitland Md.
24. FUNERAL DIRECTOR'S SIGNATURE: Reed Funeral Home
ADDRESS: Wash. D.C.
25a. REC'D BY REGISTRAR DATE MAR 15 '62
25b. REGISTRAR'S SIGNATURE: Arthur S. Thomas

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# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02553 03546

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Germantown - rural
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Found Off River Rd. in woods

2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)
a. STATE: Maryland
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 12 x 1
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First / Middle / Last: Baby Girl Unknown
4. DATE OF DEATH: Month: Mar; Day: 18; Year: 1962
5. SEX: Female
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Unknown
9. AGE (In years last birthday): 7 mo yrs; IF UNDER 1 YEAR Months Days: Jelus; IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Unknown
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Unknown
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Unknown - Estimated 7 mo. Jelus — INTERVAL BETWEEN ONSET AND DEATH

DUE TO (b) Found in gallon jar - Cord tied.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) Had been dead for several weeks

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☒

ACTUAL SIGNATURE: Frank J. Broschart M.D.
NAME (Type): FRANK J. BROSCHART
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county):
DATE SIGNED: Mar 18 1962

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 3/21/62
22c. NAME OF CEMETERY OR CREMATORY: County Alms House Cemetery
22d. LOCATION (City, town, or country) (State): Montgomery County, Maryland

23. FUNERAL DIRECTOR: Tyson Wheeler Funeral Home
ADDRESS: 1331 E. Montg. Ave.
24a. REC'D BY REGISTRAR DATE: MAR 22 '62
24b. REGISTRAR'S SIGNATURE: [illegible]

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any c[illegible] necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

2-057626

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03554 **CERTIFICATE OF DEATH** 03547

**1. PLACE OF DEATH**
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: 1 month.
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Oakhaven Convalescent Home

**2. USUAL RESIDENCE** (Where deceased lived, if institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Silver Spring
d. STREET ADDRESS: 7808 Boston Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

**3. NAME OF DECEASED** (Type or print): First: Hanna Middle: Mathilda Last: Van Dine

**4. DATE OF DEATH**: Month: March Day: 20 Year: 1962

**5. SEX**: F
**6. COLOR OR RACE**: W
**7. MARRIED** ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐
**8. DATE OF BIRTH**: July 15, 1876
**9. AGE** (In years last birthday): 85 yrs.
IF UNDER 1 YEAR: Months: Days:
IF UNDER 24 HRS.: Hours: Min.:

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): Housewife
**10b. KIND OF BUSINESS OR INDUSTRY**:
**11. BIRTHPLACE** (County & State, or foreign country): Sweden
**12. CITIZEN OF WHAT COUNTRY?**: U. S.

**13. FATHER'S NAME**: Karl Torngren
**14. MOTHER'S MAIDEN NAME**: Gertrude Gustaveson

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unkown): No
(If yes give war or dates of service): —
**16. SOCIAL SECURITY NO**: —
**17. INFORMANT**: Helman Van Dine — Address: 7808 Boston Ave. Silver Spring Md

**MEDICAL CERTIFICATION**

**18. CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Congestive heart failure — INTERVAL BETWEEN ONSET AND DEATH: 2 wks.
DUE TO (b): Generalized cardiovascular disease (arteriosclerotic) — 3 yr.
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Fracture left hip

**19. WAS AUTOPSY PERFORMED?** YES ☐ NO ☒

**20a. ACCIDENT WAS UNDERLYING** ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)
**20b. DESCRIBE HOW INJURY OCCURED.** (Enter nature of injury in Part I or Part II of item 18.)
**20c. TIME OF INJURY** Hour a.m. p.m. Month, Day, Year 19
**20d. INJURY OCCURRED** While at work ☐ Not While at work ☐
**20e. PLACE OF INJURY** (Home, farm, factory, street, office bldg., etc.)
**20f.** (City or town) (County) (State)

**21. I certify** that (I) (this hospital) attended the deceased from Jan. 2, 1962 to March 20, 1962 that (I) (we) last saw the deceased alive on 20 March 1962 and that death occured at 8:23 P.M. from the causes and on the date stated above.

**22a. SIGNATURE**: Curtis E. Garrison, M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐
**22b. DATE SIGNED**:
**22c. PHYSICIAN'S NAME** (Type):
**22d. ADDRESS**:

**23a. BURIAL, CREMATION, REMOVAL** (Specify): Burial
**23b. DATE THEREOF**: 3-24-62
**23c. NAME OF CEMETERY OR CREMATORY**: Fort Lincoln Cemetery
**23d. LOCATION** (City, town or county): Bladensburg (State): Maryland

**24. FUNERAL DIRECTOR'S SIGNATURE**: Leal Funeral Home
**ADDRESS**: 4812 Hale Ave N.W.
**25a. REC'D BY REGISTRAR** DATE MAR 27 '62
**25b. REGISTRAR'S SIGNATURE**: Arthur S. Thomas

**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed in 24 hours after death. Page 4 should be retained by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

03555 **CERTIFICATE OF DEATH** 03548

**1. PLACE OF DEATH**
a. COUNTY: Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rockville
c. LENGTH OF STAY IN 1b: MARYLAND
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Gilmore Rest Home

**2. USUAL RESIDENCE** (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rockville
d. STREET ADDRESS: 804 Maple Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

**3. NAME OF DECEASED** (Type or print): First JENNIE Middle L. Last VAN SICKLE

**4. DATE OF DEATH**: Month March Day 26, Year 19 62

**5. SEX**: Female
**6. COLOR OR RACE**: White
**7. MARRIED** ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐
**8. DATE OF BIRTH**: Sept. 7, 1890
**9. AGE** (In years last birthday): 71 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): Housewife
**10b. KIND OF BUSINESS OR INDUSTRY**: Own Home
**11. BIRTHPLACE** (County & State, or foreign country): Pennsylvania
**12. CITIZEN OF WHAT COUNTRY?**: USA

**13. FATHER'S NAME**: Edward Kindred
**14. MOTHER'S MAIDEN NAME**: Susanna Wenner

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unknown) (If yes give were or dates of service)
**16. SOCIAL SECURITY NO**
**17. INFORMANT**: F.A.VanSickle- Item # 2 — Address

**MEDICAL CERTIFICATION**

**18. CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL HEMORRHAGE — INTERVAL BETWEEN ONSET AND DEATH: Six Months

DUE TO (b) ARTERIAL Hypertension — 20 years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last — DUE TO (c) ARTERIOSCLEROSIS — 20 years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): DIABETES MELLITUS

**19. WAS AUTOPSY PERFORMED?** YES ☐ NO ☒

**20a. ACCIDENT WAS UNDERLYING** ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)
**20b. DESCRIBE HOW INJURY OCCURRED.** (Enter nature of injury in Part I or Part II of item 18.)

**20c. TIME OF INJURY** Month, Day, Year — Hour a.m. p.m. 19
**20d. INJURY OCCURRED** While at work ☐ Not While at work ☐
**20e. PLACE OF INJURY** (Home, farm, factory, street, office bldg., etc.)
**20f.** (City or town) (County) (State)

21. **I certify** that (I) ~~(this hospital)~~ attended the deceased from Jan 2, 1956 to Mar 26, 1962, that (I) ~~(we)~~ last saw the deceased alive on Jan 23, 1962, and that death occured at 9:20 A.M., from the causes and on the date stated above.

**22a. SIGNATURE**: Gordon S. Rosenberger M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
**22b. DATE SIGNED**: 3/26/62
**22c. PHYSICIAN'S NAME** (Type): Gordon S. Rosenberger, M.D.
**22d. ADDRESS**: 310 W. Montg. Ave, Rockville, Md.

**23a. BURIAL, CREMATION, REMOVAL** (Specify): Burial
**23b. DATE THEREOF**: 3/28/62
**23c. NAME OF CEMETERY OR CREMATORY**: Union
**23d. LOCATION** (City, town or county) (State): Burtonsville, Md.

**24 FUNERAL DIRECTOR'S SIGNATURE** — ADDRESS: Tyson Wheeler Funeral Home-1331 E. Montg. Ave. Rockville, Md.
**25a. REC'D BY REGISTRAR** DATE MAR 27 '62
**25b. REGISTRAR'S SIGNATURE**: Louise L. Hines

**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

03556 **CERTIFICATE OF DEATH** 03549

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: 18 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Washington San. + Hosp.

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: ~~Maryland~~ VIRGINIA
b. COUNTY: WARREN
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ~~College Park~~ BROWNTOWN
d. STREET ADDRESS: ~~Wm College Ave~~
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Minnie; Middle MARIA; Last Van Valey
4. DATE OF DEATH: Month 3; Day 8; Year 1962
5. SEX: Fe
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 12-12-95
9. AGE (In years last birthday): 66 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House mother
10b. KIND OF BUSINESS OR INDUSTRY: Univ. of Maryland
11. BIRTHPLACE (County & State, or foreign country): Collegeville, Pennsylvania
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Edwin Jesse J. LaRose
14. MOTHER'S MAIDEN NAME: Susan Sarah Hunsicker
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes give war or dates of service): None
16. SOCIAL SECURITY NO.: 095-30-6200
17. INFORMANT: Hospital Records — Address:

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 13 days
DUE TO (b) Coronary atherosclerosis — Several years
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): 1. Bile Peritonitis, Localized, 2. Diabetes Mellitus, 3. Cholecystitis, 4. Lower Nephron Nephrosis, Cholithiasis

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) ~~(this hospital)~~ attended the deceased from October, 1960 to March 8, 1962 ~~that~~ (I) ~~(we)~~ last saw the deceased alive on March 7, 1962 and that death occured at 1:35 p.M. from the causes and on the date stated above.

22a. SIGNATURE: Russell B. Arnold M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: March 9, 1962
22c. PHYSICIAN'S NAME (Type): Russell B. Arnold M.D.
22d. ADDRESS: 8801 Colesville Road, Silver Spring, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 3-11-62
23c. NAME OF CEMETERY OR CREMATORY: Trinity Reformed Church of Collegeville Cemetery
23d. LOCATION (City, town or county): Collegeville Montgomery Co. (State): Pennsylvania

24. FUNERAL DIRECTOR'S SIGNATURE: Raymond C. Zibel — ADDRESS: 134 Georgia Ave
Warner E. Pumphrey, Inc. Silver Spring, Md.
25a. REC'D BY REGISTRAR: DATE MAR 12 '62
25b. REGISTRAR'S SIGNATURE: [illegible]

MEDICAL CERTIFICATION

**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 is retained by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

03557 **CERTIFICATE OF DEATH** 03550

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Montgomery

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
c. LENGTH OF STAY IN 1b: 9 years

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 21 Silver Spring

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 201 Williamsburg Drive

d. STREET ADDRESS: 201 Williamsburg Drive

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First JAMES Middle FRANCIS Last VERMILLION

4. DATE OF DEATH: Month 3 Day 18 Year 1962

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Aug. 11, 1917
9. AGE (In years last birthday): 44 yrs
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Inspector
10b. KIND OF BUSINESS OR INDUSTRY: Pepco
11. BIRTHPLACE (State or foreign country): Washington, D.C.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Charles T. Vermillion
14. MOTHER'S MAIDEN NAME: Delia Dorsey

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): WWII
16. SOCIAL SECURITY NO: 579-03-4441
17. INFORMANT: Alice L. Vermillion Address: 201 Williamsburg Dr, S.S., Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I DEATH WAS CAUSED BY:
(a) IMMEDIATE CAUSE: CORONARY OCCLUSION — INTERVAL BETWEEN ONSET AND DEATH: IMMED.
DUE TO
(b) ARTERIOSCLEROTIC VASCULAR DIS. — 10 YRS
DUE TO
(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): PERIPHERAL VASCULAR DISEASE

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I **certify** that (I) (this hospital) attended the deceased from 1959 to March 1962 that (I) (—) last saw the deceased alive on 3-15 1962 and that death occurred at 6 A.M., from the causes and on the date stated above.

22a. SIGNATURE: Bernard A. Fitzgerald M.D.
ATTENDING PHYS. ☒ MED DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED: 3-18-62
22c. PHYSICIAN'S NAME (Type): BERNARD A. FITZGERALD
22d. ADDRESS: 217 UNIV. BLVD. E. SIL. SP. Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 3-21-62
23c. NAME OF CEMETERY OR CREMATORY: Arlington National Cemetery
23d. LOCATION (City, town, or county) (State): Arlington, Virginia

24. FUNERAL DIRECTOR'S SIGNATURE: Raymond A. Ziska ADDRESS: 8134 Georgia Ave
Warner E. Pumphrey, Inc. Silver Spring, Maryland
25a. REC'D BY REGISTRAR DATE MAR 20 '62
25b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

CORONER HAS BEEN NOTIFIED AND APPROVES

VR A15 (4)
1SM 9/59

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

03551

**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be exe[illegible]in 24 hours after death. Page 1 should be retained by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely [illegible]ed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda (Rural)
c. LENGTH OF STAY IN 1b: 76 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): U. S. Naval Hospital

2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)
a. STATE: Pennsylvania
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hustontown
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Mary Middle: Madaline Last: Vitti
4. DATE OF DEATH: Month: March Day: 31, Year: 1962
5. SEX: Female
6. COLOR OR RACE: Caucasian
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: January 20, 1921
9. AGE (In years last birthday): 41 yrs. IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Pennsylvania
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Jack Hann
14. MOTHER'S MAIDEN NAME: UNK
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No (If yes give war or dates of service): ----------
16. SOCIAL SECURITY NO.: UNK
17. INFORMANT: Samuel J. Vitti Address: Same As # 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a): Carcinomatosis — INTERVAL BETWEEN ONSET AND DEATH: 3 mos.
153.8
DUE TO (b): Metastatic Carcinoma of Colon
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that ~~I~~ (this hospital) attended the deceased from January 5, 1962, to March 31, 1962, that ~~I~~ (we) last saw the deceased alive on March 31, 1962, and that death occured at 1:00 AM from the causes and on the date stated above

22a. SIGNATURE: William P. Baker M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type): William P. Baker, LT MC USN
22d. ADDRESS: U.S. Naval Hospital, Bethesda, Md.

23a. BURIAL, CREMATION REMOVAL (Specify): Burial
23b. DATE THEREOF: 4-3-62
23c. NAME OF CEMETERY OR CREMATORY: Arlington National
23d. LOCATION (City, town or county): Arlington, Virginia (State)
24. FUNERAL DIRECTOR'S SIGNATURE: Pearson Funeral Home, 472 N. Wash. St., Falls Church, Va.
25a. REC'D BY REGISTRAR DATE APR 3 '62
25b. REGISTRAR'S SIGNATURE

VR A15 (4)
15M 7 61

# MARYLAND STATE DEPARTMENT OF HEALTH

**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

03559 **CERTIFICATE OF DEATH** 03552

**1. PLACE OF DEATH**
a. COUNTY: Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN MARYLAND: 3 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): The Clinical Center, Bethesda 14, Md.

**2. USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
a. STATE: Virginia
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Blacksburg,
d. STREET ADDRESS: 207 Rose Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

**3. NAME OF DECEASED** (Type or print): First: James Middle: Harris Last: Wardlaw

**4. DATE OF DEATH** Month: March Day: 7, Year: 1962

**5. SEX:** Male **6. COLOR OR RACE:** White **7. MARRIED** ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐ **8. DATE OF BIRTH:** 2 December 1913 **9. AGE** (In years last birthday): 48 yrs. IF UNDER 1 YEAR: Months 3 Days 5 IF UNDER 24 HRS.: Hours Min.

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): Dept. Store Manager
**10b. KIND OF BUSINESS OR INDUSTRY:** Department Store
**11. BIRTHPLACE** (County & State or foreign country): South Carolina
**12. CITIZEN OF WHAT COUNTRY?** U.S.A.

**13. FATHER'S NAME:** Joseph M. Wardlaw
**14. MOTHER'S MAIDEN NAME:** Aurie Cox

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unkown) No (If yes give war or dates of serv.ce)
**16. SOCIAL SECURITY NO.:** 237-03-3195
**17. INFORMANT:** The Medical Record, Address: The Clinical Center, Bethesda 14, Maryland

**MEDICAL CERTIFICATION**

**18. CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Aortic Insufficiency — INTERVAL BETWEEN ONSET AND DEATH: 4 hours
DUE TO (b) Aortic Stenosis — 10 years
DUE TO (c) Rheumatic Heart Disease, Inactive — 10 years

411X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

**19. WAS A AUTOPSY PERFORMED?** YES ☒ NO ☐

**20a. ACCIDENT WAS UNDERLYING** ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)
**20b. DESCRIBE HOW INJURY OCCURED.** (Enter nature of injury in Part I or Part II of item 18.)
**20c. TIME OF INJURY** Hour a.m. p.m. Month, Day, Year 19
**20d. INJURY OCCURRED** While at work ☐ Not While at work ☐
**20e. PLACE OF INJURY** (Home, farm, factory, street, office bldg., etc.)
**20f.** (City or town) (County) (State)

**21. I certify** that (I) (this hospital) attended the deceased from March 4, 1962 to March 7, 1962, that (I) (we) last saw the deceased alive on March 7, 1962, and that death occured at 4:30 P.M. from the causes and on the date stated above.

**22a. SIGNATURE** W. B. Berry M.D.
**22b. DATE SIGNED** March 8, 1962
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
**22c. PHYSICIAN'S NAME** (Type) W. B. Berry, M.D.
**22d. ADDRESS** The Clinical Center, National Institutes of Health, Bethesda 14, Md.

**23a. BURIAL, CREMATION, REMOVAL** (Specify): Bur-transit
**23b. DATE THEREOF:** 3/8/1962
**23c. NAME OF CEMETERY OR CREMATORY:** Silver Brook
**23d. LOCATION** (City, town or county) (State): Anderson County So. Carolina

**24 FUNERAL DIRECTOR'S SIGNATURE:** Robert A. Pumphrey
**ADDRESS:** Bethesda, Maryland
**25a. REC'D BY REGISTRAR** DATE MAR 14 '62
**25b. REGISTRAR'S SIGNATURE** Clifton E. Kraus

**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed [illegible] 24 hours after death. Pa[illegible] retained by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely [illegible] by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1II (4)
15M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03560

## CERTIFICATE OF DEATH

03553

**1. PLACE OF DEATH**
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Damascus
c. LENGTH OF STAY IN 1b: years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 26920 Howard Chapel Dr.

**2. USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Damascus
d. STREET ADDRESS: 26920 Howard Chapel Dr.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Marshall — Middle T. — Last Watkins
4. DATE OF DEATH: Month March — Day 23 — Year 19 62
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: April 3, 1886
9. AGE (In years last birthday): 75 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10b. KIND OF BUSINESS OR INDUSTRY: Building
11. BIRTHPLACE (County & State, or foreign country): Damascus, Md.
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Uriah Watkins
14. MOTHER'S MAIDEN NAME: Margaret Brown
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No (If yes give wars or dates of service)
16. SOCIAL SECURITY NO.: 578-44-7826
17. INFORMANT: Mrs Mattie E. Watkins, Item 2 — Address

**MEDICAL CERTIFICATION**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease — INTERVAL BETWEEN ONSET AND DEATH: 10 years
DUE TO (b)
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 1/15, 1963 to 3/23, 1962 that (I) (we) last saw the deceased alive on 3/23 1962 and that death occured at 7P.M. from the causes and on the date stated above.

22a. SIGNATURE: James P. Kerr M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 3/24/62
22c. PHYSICIAN'S NAME (Type): James P. Kerr
22d. ADDRESS: Damascus, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 3/26/62
23c. NAME OF CEMETERY OR CREMATORY: Montgomery Meth.
23d. LOCATION (City, town or county): Clagettsville, Md. (State)

24 FUNERAL DIRECTOR'S SIGNATURE: Olin L. Molesworth
ADDRESS: Damascus, Md.
25a. REC'D BY REGISTRAR: DATE MAR 27 '62
25b. REGISTRAR'S SIGNATURE: Luther S. Thomas

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/60

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FOR STATE HEALTH DEPT.

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If [illegible] is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH 03554

02561

1. PLACE OF DEATH
a. COUNTY: Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
c. LENGTH OF STAY IN 1b: 4 years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 9918 Markham St.

MARYLAND

2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montg.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 30 Silver Spring
d. STREET ADDRESS: 9918 Markham St
e. IS RESIDENCE ON A FARM? YES [ ] NO [X]

3. NAME OF DECEASED (Type or print): First: Ruth Middle: Gertrude Last: Whittemore

4. DATE OF DEATH: Month: March Day: 4 Year: 19 62

5. SEX: female
6. COLOR OR RACE: white
7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]
8. DATE OF BIRTH: Dec. 1, 1913
9. AGE (In years last birthday): 48 yrs. IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Nurse
10b. KIND OF BUSINESS OR INDUSTRY: Wash. Hosp. Center
11. BIRTHPLACE (State or foreign country): Washington County, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: James R. Whitlock
14. MOTHER'S MAIDEN NAME: Susie D. Taylor

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No (If yes give war or dates of service): None
16. SOCIAL SECURITY NO: yes
17. INFORMANT: Charles H. Whitlock Address: 2014 Drexel St., S.S., Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): 3rd degree burns involving 100% of body — INTERVAL BETWEEN ONSET AND DEATH: sudden
916.0
DUE TO (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. EXTERNAL CAUSE WAS PRIMARY [X] or CONTRIBUTING [ ] CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.): Found dead in bed which was completly burned
20c. TIME OF INJURY: 1:15 a.m. p.m. Month, Day, Year: 4/4 1962
20d. INJURY OCCURRED: While at work [ ] Not While at work [X]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): home
20f. (City or town): Silver Spring (County): Montg. (State): Md.

21. I certify that I took charge of the remains described above, held an Autopsy [ ], Inspection [X], Inquiry [X], and in my opinion death resulted from. Natural causes [ ], Accident [X], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE: Frank J. Broschart M.D
NAME (Type): Frank J. Broschart
CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]
DATE SIGNED: 4/4/62
Address (Street, city, town, or county)

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 3-6-62
22c. NAME OF CEMETERY OR CREMATORY: Arlington National Cemetery
22d. LOCATION (City, town, or country): Arlington, Virginia (State):

23. FUNERAL DIRECTOR: Raymond A. Zieka ADDRESS: 8434 Georgia Ave
Warner E. Pumphrey, Inc. Silver Spring, Md.
24a. REC'D BY REGISTRAR DATE: MAR 7 '62
24b. REGISTRAR'S SIGNATURE: [illegible]

# MARYLAND STATE DEPARTMENT OF HEALTH

**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

03562 **CERTIFICATE OF DEATH** 03555

**1. PLACE OF DEATH** a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Kensington
c. LENGTH OF STAY IN 1b: 9 mo.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 3906 Spruell Court

**2. USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 25 Kensington
d. STREET ADDRESS: 3906 Spruell Court
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

**3. NAME OF DECEASED** (Type or print): First: Roy Middle: R. Last: Wilburn

**4. DATE OF DEATH** Month: March Day: 17 Year: 1962

**5. SEX:** Male **6. COLOR OR RACE:** White **7. MARRIED** ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

**8. DATE OF BIRTH:** Oct. 10, 1897

**9. AGE** (In years last birthday): 64 yrs. IF UNDER 1 YEAR: Months Days. IF UNDER 24 HRS.: Hours Min.

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): Carpenter
**10b. KIND OF BUSINESS OR INDUSTRY:** Construction
**11. BIRTHPLACE** (County & State, or foreign country): Maryland
**12. CITIZEN OF WHAT COUNTRY?** USA

**13. FATHER'S NAME:** Wm. J. Wilburn
**14. MOTHER'S MAIDEN NAME:** Annie Durst

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unknown): No (If yes give war or dates of service)
**16. SOCIAL SECURITY NO.:** 217-03-8958
**17. INFORMANT:** James H. Edwards-Item# 2 Address

**18. CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis — INTERVAL BETWEEN ONSET AND DEATH: June, 1961 (?)
DUE TO (b) Bronchogenic carcinoma — June, 1961
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a). **19. WAS AUTOPSY PERFORMED?** YES ☐ NO ☒

MEDICAL CERTIFICATION

**20a.** ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
**20b.** DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
**20c.** TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
**20d.** INJURY OCCURRED While at work ☐ Not While at work ☐
**20e.** PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
**20f.** (City or town) (County) (State)

**21. I certify** that (I) (~~this hospital~~) attended the deceased from March 14, 1962 to March 17, 1962, that (I) (~~we~~) last saw the deceased alive on March 14, 1962 and that death occured at 9:00 A.M., from the causes and on the date stated above.

**22.** SIGNATURE: George A. Gray, Jr. M.D.
**22a.** PHYSICIAN'S NAME (Type): George A. Gray, Jr. M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
**22b.** DATE SIGNED
**22d.** ADDRESS: 4740 Chevy Chase Dr., Chevy Chase, Md.

**23a.** BURIAL, CREMATION, REMOVAL (Specify): BURIAL
**23b.** DATE THEREOF: 3/20/62
**23c.** NAME OF CEMETERY OR CREMATORY: GRANTSVILLE
**23d.** LOCATION (City, town or county) (State): GRANTSVILLE, GARRETT Co., MD

**24** FUNERAL DIRECTOR'S SIGNATURE: Don Newman ADDRESS: Grantsville, Md
**25a.** REC'D BY REGISTRAR DATE MAR 20 '62
**25b.** REGISTRAR'S SIGNATURE: Arthur S. Krause

**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed in 24 hours after death. Page 4 should be retained by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03563 **CERTIFICATE OF DEATH** 03556

1. PLACE OF DEATH
a. COUNTY: Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 2 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): The Clinical Center, Bethesda 14, Md.

2. USUAL RESIDENCE (Where deceased lived, If Institution, Residence before admission)
a. STATE: North Carolina
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Statesville
d. STREET ADDRESS: 402 Hillcrest Drive
e. RESIDENCE ON A FARM? YES ☐ NO ☒

70X 3

3. NAME OF DECEASED (Type or print): First Helen, Middle Louise, Last Wilson

4. DATE OF DEATH: Month March, Day 2, Year 1962

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: December 10, 1922

9. AGE (In years last birthday): 39 yrs. IF UNDER 1 YEAR: Months, Days. IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Not applicable

11. BIRTHPLACE (County & State, or foreign country): North Carolina

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Bunk Sherrill

14. MOTHER'S MAIDEN NAME: Lillian Cline

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT: The Medical Record (Address) The Clinical Center, Bethesda 14, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Hypotension, Circulatory Failure — Interval between onset and death: 2 hours
DUE TO (b) Gram Negative Septicemia — 3 days
DUE TO (c) Acute Lymphoblastic Leukemia — 1 month

204.3

Conditions, if any, which give rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that ☒ (this hospital) attended the deceased from February 28, 1962 to March 2, 1962, that ☒ (we) last saw the deceased alive on March 2, 1962, and that death occured at 7:35 PM from the causes and on the date stated above.

22a. SIGNATURE: Marvin A. Kirschner, M.D.

22b. DATE SIGNED: 3-3-62

ATTENDING PHYS. ☐ MED DIRECTOR ☐ STAFF PHYS. ☐

22c. PHYSICIAN'S NAME (Type): Marvin A. Kirshner, M.D.

22d. ADDRESS: The Clinical Center, National Institutes of Health, Bethesda 14, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial-transit

23b. DATE THEREOF: 3-3-62

23c. NAME OF CEMETERY OR CREMATORY: Iredell Memorial Park,

23d. LOCATION (City, town or county) (State): Statesville, No. Carolina

24. FUNERAL DIRECTOR'S SIGNATURE: ROBERT A. PUMPHREY

ADDRESS: Bethesda, Md.

25a. REC'D BY REGISTRAR: DATE MAR 1 '62

25b. REGISTRAR'S SIGNATURE: Arthur S. Krause

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1

FOR STATE HEALTH DEPT.

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03564

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03557

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Poolesville (rural)
c. LENGTH OF STAY IN 1b: DOA
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Willard Rd

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Va
b. COUNTY: Tazewell
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Tounding Mill
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Ealy — Middle: Homer — Last: Wingo
4. DATE OF DEATH: Month: Mar — Day: 10 — Year: 1962

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Nov-3-1896
9. AGE (In years last birthday): 65 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Va
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Thomas Wingo
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: 223-40-1496
17. INFORMANT: Pierce Wingo — Address: Poolesville Md - R-2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Internal hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: sudden
DUE TO (b): Crushed chest
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a): Fracture of left thigh

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.): Passenger in car involved in accident
20c. TIME OF INJURY: Hour 7:15 p.m. — Month, Day, Year: 3-10 1962
20d. INJURY OCCURRED: While at work ☐ Not While at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): highway
20f. (City or town): Poolesville — (County): Monty — (State): Md

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ and in my opinion death resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Frank J. Broschart M.D.
EXAMINER'S NAME (Type): FRANK J. BROSCHART
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county):
DATE SIGNED: 3-10-62

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 3/14/62
22c. NAME OF CEMETERY OR CREMATORY: Gillispie
22d. LOCATION (City, town, or country) (State): Tazewell, Virginia

23. FUNERAL DIRECTOR: William B. Helton
ADDRESS: Barnesville, Md
24a. REC'D BY REGISTRAR: DATE MAR 15 '62
24b. REGISTRAR'S SIGNATURE: [illegible]

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any [illegible] is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. ASME 5M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03565

## CERTIFICATE OF DEATH

03558

**TO ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 3 should be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda (rural)
c. LENGTH OF STAY IN 1b: 3 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): U.S. Naval Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: District of Columbia
b. COUNTY: MARYLAND
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington D.C.
d. STREET ADDRESS: 615 Alabama Ave S.E. Apt#1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Paul; Middle: John; Last: WISNIEWSKI

4. DATE OF DEATH: Month: March; Day: 26; Year: 1962

5. SEX: Male

6. COLOR OR RACE: Cauc

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 23 March 1962

9. AGE (In years last birthday): yrs; IF UNDER 1 YEAR: Months; Days: 3; IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): - - - -

10b. KIND OF BUSINESS OR INDUSTRY: - - - -

11. BIRTHPLACE (County & State, or foreign country): Montgomery, Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Ronald R. Wisniewski

14. MOTHER'S MAIDEN NAME: Nancy Ann Sugyik

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Prematurity
DUE TO
(b) Post op status 2 days closure of Omphalocele
DUE TO
(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that ☒ (this hospital) attended the deceased from 23 March, 1962 to 26 March, 1962, that ☐ (we) last saw the deceased alive on 26 March 1962, and that death occured at 1:12 AM from the causes and on the date stated above.

22a. SIGNATURE: Lawrence G. Thorne M.D.

22b. DATE SIGNED: 26 March 1962

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22c. PHYSICIAN'S NAME (Type): L.G. Thorne, LT MC USN

22d. ADDRESS: U.S. Naval Hospital Bethesda Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 3-27-62

23c. NAME OF CEMETERY OR CREMATORY: Arlington National

23d. LOCATION (City, town or county) (State): Arlington, Virginia

24. FUNERAL DIRECTOR'S SIGNATURE: Tyson Wheeler

ADDRESS: Rockville, Md.

Tyson-Wheeler Funeral Home, 1331 E. Montgomery Ave.

25a. REC'D BY REGISTRAR DATE MAR 28 '62

25b. REGISTRAR'S SIGNATURE: Arthur S. Thomas

VR A15 (4)
15M 7 61

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# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03566

## CERTIFICATE OF DEATH

Items 8&9 FilmG311 4/12/62 jwk 03559

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): OLNEY
c. LENGTH OF STAY IN 1b: 15 MINS.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MONTGOMERY GENERAL HOSPITAL

MARYLAND

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: PENNSYLVANNIA
b. COUNTY: DELAWARD
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ARDMORE
d. STREET ADDRESS: 18 HANNUM DRIVE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First HENRIETTA Middle MARIE Last WOLF

4. DATE OF DEATH: Month 3 Day 20 Year 62

5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 10-27-1892
9. AGE (In years last birthday): 69/71 yrs. IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED R. N.
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (City or town, State, or foreign country): ENGLAND
12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME: UNKNOWN (PAYTON)
14. MOTHER'S MAIDEN NAME: (UNKNOWN)
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): NO (If yes give war or dates of service): NONE
16. SOCIAL SECURITY NO.:
17. INFORMANT: HOSPITAL RECORDS Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

| | | Interval between onset and death |
|---|---|---|
| IMMEDIATE CAUSE (a) | MESENTERIC THROMBOSIS | 24 HRS |
| DUE TO (b) | MURAL THROMBOSIS, LEFT AURICLE | 1 MONTH |
| DUE TO (c) | MITRAL STENOSIS | ? 20 YRS |

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): CEREBRAL THROMBOSIS, LEFT HEMISPHERE

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, off ce bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from FEB 11, 1962 to MAR. 20, 1962 that (I) (~~we~~) last saw the deceased alive on MAR. 20 1962 and that death occured at 7:30A M, from the causes and on the date stated above.

22a. SIGNATURE: Charles S. Whitaker, M.D.
22b. DATE SIGNED: 3-20-62
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22c. PHYSICIAN'S NAME (Type): CHARLES S. WHITAKER, M.D.
22d. ADDRESS: CLARKSVILLE, MARYLAND

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 3-24-62
23c. NAME OF CEMETERY OR CREMATORY: Westminister
23d. LOCATION (City, town or county) (State): Philadelphia, Pa.

24. FUNERAL DIRECTOR'S SIGNATURE: F.C.Higinbothom, Ellicott City, Md
ADDRESS:

25a. REC'D BY REGISTRAR DATE APR 22 '62
25b. REGISTRAR'S SIGNATURE: Wilbur L. Thomas

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed in 24 hours after death. Page 1 should be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/6f

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FOR STATE HEALTH DEPT.

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**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any questions are necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03567

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03560

Items 13 & 14 Film G308 3/12/62 jwk

**1. PLACE OF DEATH**
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
c. LENGTH OF STAY IN 1b: 8 mo.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 8600 Manchester Rd

**2. USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
a. STATE: Md
b. COUNTY: Monty
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 23 Silver Spring
d. STREET ADDRESS: 8600 Manchester Rd
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

**3. NAME OF DECEASED** (Type or print): First: Helen; Middle: Hawthorne; Last: Zimmerman

**4. DATE OF DEATH**: Month: Mar; Day: 5; Year: 1962

**5. SEX**: Female
**6. COLOR OR RACE**: White
**7. MARRIED** ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐
**8. DATE OF BIRTH**: Sept. 15, 1899
**9. AGE** (In years last birthday): 62 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): housewife
**10b. KIND OF BUSINESS OR INDUSTRY**: Own home
**11. BIRTHPLACE** (State or foreign country): N. J.
**12. CITIZEN OF WHAT COUNTRY?**: U.S.A.

**13. FATHER'S NAME**: (unknown) ~~Helen~~ John Munn Baldwin
**14. MOTHER'S MAIDEN NAME**: (unknown) // Helen Hawthorne

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unkown): No — (If yes give wars or dates of service): None
**16. SOCIAL SECURITY NO.**: 148-07-2731
**17. INFORMANT**: Marcel Zimmerman — Address: Glen 2

**MEDICAL CERTIFICATION**

**18. CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: sudden
DUE TO (b) Arterio sclerosis — yrs
DUE TO (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

**19. WAS AUTOPSY PERFORMED?** YES ☐ NO ☒

**20a. EXTERNAL CAUSE WAS** PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
**20b. DESCRIBE HOW INJURY OCCURED.** (Enter nature of injury in Part I or Part II of item 18.)
**20c. TIME OF INJURY** Hour a.m. p.m. Month, Day, Year 19
**20d. INJURY OCCURRED** While at work ☐ Not While at work ☐
**20e. PLACE OF INJURY** (Home, farm, factory, street, office bldg., etc.)
**20f.** (City or town) (County) (State)

**21. I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Frank J. Broschart M.D.
EXAMINER'S NAME (Type): FRANK J. BROSCHART
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county)
DATE SIGNED: 3-5-62

**22a. BURIAL, CREMATION, REMOVAL** (Specify): Burial
**22b. DATE THEREOF**: 3-7-62
**22c. NAME OF CEMETERY OR CREMATORY**: Arlington National Cemetery
**22d. LOCATION** (City, town, or country) (State): Arlington, Virginia

**23. FUNERAL DIRECTOR**: Raymond A. Zisk — ADDRESS: 8434 Georgia Ave.
Warner E. Pumphrey, Inc. Silver Spring, Maryland

**24a. REC'D BY REGISTRAR** — DATE: MAR 7 '62
**24b. REGISTRAR'S SIGNATURE**: Arthur S. Kraus

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

3568 — 03568 — Item 2 Film G311 4/24/62 jwk — 03561

**1. PLACE OF DEATH** a. COUNTY: Montgomery — MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Kensington

c. LENGTH OF STAY IN 1b:

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Kensington Gardens Sanitorium

**2. USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission) a. STATE: Minnesota b. COUNTY:

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): WASHINGTON D.C. Box-3

d. STREET ADDRESS: 919 - 4th. Avenue N.E. 4357 ALTON PL NW

e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

**3. NAME OF DECEASED** (Type or print): First: FRANCES Middle: K Last: ZIMPRICH

**4. DATE OF DEATH** Month: Mar. Day: 11 Year: 1962

**5. SEX:** F

**6. COLOR OR RACE:** W

**7. MARRIED** ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

**8. DATE OF BIRTH:** 5/15/88

**9. AGE** (In years last birthday): 73 yrs. IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hours: Min.:

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): HOUSEWIFE

**10b. KIND OF BUSINESS OR INDUSTRY:**

**11. BIRTHPLACE** (County & State, or foreign country): Wisconsin

**12. CITIZEN OF WHAT COUNTRY?** USA

**13. FATHER'S NAME:** J. M. Straus

**14. MOTHER'S MAIDEN NAME:** Margaret Barth

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unkown): NO (If yes give war or dates of service): —

**16. SOCIAL SECURITY NO.:** 577-56-1991

**17. INFORMANT:** MELBA Z. TEMPLEMAN Address: 4357 ALTON PL NW

**MEDICAL CERTIFICATION**

**18. CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cerebral thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 1 yrs

DUE TO (b): Generalized arteriosclerosis

DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Diabetes mellitus

**19. WAS AUTOPSY PERFORMED?** YES ☐ NO ☑

**20a. ACCIDENT WAS UNDERLYING** ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

**20b. DESCRIBE HOW INJURY OCCURED.** (Enter nature of injury in Part I or Part II of item 18.)

**20c. TIME OF INJURY** Hour a.m. p.m. Month, Day, Year 19

**20d. INJURY OCCURRED** While at work ☐ Not While at work ☐

**20e. PLACE OF INJURY** (Home, farm, factory, street, office bldg., etc.)

**20f.** (City or town) (County) (State)

**21. I certify** that (I) (this hospital) attended the deceased from 3/2/62, 19 to 3/11, 1962 that (I) (we) last saw the deceased alive on 3/10, 1962 and that death occured at 10 A.M. from the causes and on the date stated above.

**22a. SIGNATURE:** Donald Nelson M.D.

ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐

**22b. DATE SIGNED:**

**22c. PHYSICIAN'S NAME** (Type): DONALD NELSON MD

**22d. ADDRESS:** 10620 - GA. AVE. SIL. SP. MD.

**23a. BURIAL, CREMATION, REMOVAL** (Specify): BURIAL

**23b. DATE THEREOF:** MARCH 16, 1962

**23c. NAME OF CEMETERY OR CREMATORY:** CATHOLIC CEMETERY

**23d. LOCATION** (City, town or county) (State): AUSTIN, MINNESOTA

**24 FUNERAL DIRECTOR'S SIGNATURE** ADDRESS: Timothy Hanlon — 4748 - Wisc. Av.

**25a. REC'D BY REGISTRAR** DATE MAR 19 '62

**25b. REGISTRAR'S SIGNATURE:** Clifton E. Krause

**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 7/61